Access to and Utilization of Health Care for Young Homeless Mothers in Durban, South Africa

Durban, KwaZulu-Natal, South Africa

Kaja Fjell Jørgensen

Supervisor:
Professor Joar Svanemyr

Co-supervisors:
Professor Claudia Mitchell

University of Oslo
Faculty of Medicine
Institute of General Practice and Community Medicine
Section for International Health

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Abstract

This is a study about young homeless mothers and their perspective of health and experiences with access to and utilization of health care. The study was conducted in Durban, South Africa with a group of eleven young homeless mothers. This is a qualitative study, and we used observation, individual interviews and focus groups to collect data in the field.

Youth who are homeless face several threats to their health, and is considered vulnerable for negative health outcomes. Despite this fact it has been shown that this population group lacks access to health care services. To improve this situation it is vital that we learn more about how this population views health and about their experiences with health care.

We found that how young homeless mothers are treated when they seek health care is of vital importance for this population's health seeking behavior. Poor treatment by health care staff deterred the participants from seeking health care. However, in spite of this barrier the participants still accessed and utilized health care. This can partly be explained by few other barriers to health care for this population in Durban, and due to a relatively high awareness of health and illness.

With this study we have found that we should focus on young homeless mothers' strengths rather than their vulnerabilities. The participants were able to access health care in spite of the barriers they had to overcome. Although full utilization of the services became difficult due to harsh treatment from health care staff, they still chose to seek help as several of them were dependent on professional health care to take care of themselves and their children. These young homeless mothers were able to get the help they needed although they fall outside of the system as a group, and this is a strength we should focus on when trying to create better access to health care for this population.

ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
DHC	District Health Care System
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
ID	Identification Document
NGO	Non Governmental Organization
PHC	Primary Health Care
STI	Sexually Transmitted Infections
TB	Tuberculosis

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1. Introduction

Jabulile is 21 years old. She is homeless and she is a mother, at least by definition, as she has given birth to a child. Her child passed away a few years ago, however, she talks about him like it was just yesterday he passed away.

Jabulile lives on the streets of Durban. She sleeps under some trees on a small patch next to an electrical box. The box provides some heat in the cold nights, and the trees provide shelter from the rain. This is her base, and she lives her together with her boyfriend and a group of other homeless youth and children.

Jabulile is HIV positive. She explains that this is one of the reasons she is now living on the streets of Durban. Her friends started teasing her about her status when she was still living at home, and her friends' parents kept them from playing with her, they were scared their children would get AIDS from her. However, HIV was not the only reason Jabulile became homeless. Her mother is a single parent and unemployed, which made it very difficult for Jabulile to live at home because she was unable to take care of her.

Jabulile does not have an ID. This is something that on occasions keeps her from accessing health care. However, Jabulile has been living on the streets for a long time, and she knows how to get help when she needs it. She has developed some acquaintances at the clinic she normally goes to, and she possesses a certain agency that she uses to get passed the guards at the clinic, which allows her to access health care without an ID. Although Jabulile is able to access health care, she explains that she does not always like the way the health workers treat her. Sometimes they yell at her for living on the street, other times they are rude and judgmental. But some of the health workers are nice, and she explains that you can never know if you are going to meet a nice person or a bad person. This is why she still seeks health care when she has a problem, because she might meet someone who is nice.

Jabulile lives a difficult life. She has many worries; her HIV status, her deceased child, her mother, and the general hazards of living on the streets. However, she is a happy young woman. She has aspirations of getting a job and a house, and to be able to take care of herself. Her days consist of hanging with her friends, braiding each others hair, and swimming in the sea.

Jabulile is one example of how it is to be a homeless mother in down town Durban. She is homeless as a result of several reasons, she faces many difficulties in her everyday life, but her agency and personal attributes makes her able to survive on the street in a country that is described

as having one of the highest crime-rates in the world. She still has her sense of optimism that one day she will have a home, which makes her able to face another day on the streets of Durban.

Jabulile is one of the young homeless mothers we meet in this study. The study is about a group of young homeless mothers, their perceptions on and experiences with health and access to and utilization of health care.

1.1 Rationale for study

Young homeless mothers can be categorized as a part of the homeless youth population. Homeless youth is a population that generally have low access to health care all over the world. However, some groups among the homeless population are at higher risk of not receiving health care than others, and it has been shown that young homeless women is the group with the lowest access to health care (Ensign & Panke, 2002). To improve the situation of health care for homeless youth we need to get their own perspective of health and access to health. It is essential to hear from the homeless youth themselves what is causing difficulties and what could possible create a better situation (Hudson et al, 2008).

Since the end of apartheid in 1994, and the transition to a new government in South Africa, there has been considerable effort put into the health system in the country, with focus on primary care and equity (Benatar, 2004). The government has also focused on creating better access to health care, with special emphasis on the most vulnerable. Women and children of lower socioeconomic status are considered a part of the vulnerable population in South Africa. Young homeless mothers are a part of this group, and by exploring their perspectives and experiences with health and access to health care, we can possibly gain some knowledge on how accessible the South African health care system is to one of the most vulnerable populations in the country.

This study will hopefully provide some insight into the lives of young homeless mothers who live in Durban and their access to health care. The intention is that this insight could be helpful when wanting to create a better situation for young homeless mothers and homeless youth in South Africa in terms of access to and utilization of health care.

2. Background

2.1 Health and Illness in South Africa

Inequality is a word that describes South Africa well. It is a country filled with contrasts; beautiful nature and large areas of shack dwellings, affluent people and poor people, some live without a care in the world, others live with HIV and TB. In terms of resources and access to resources, South Africa has one of the most unequal distributions in the world. Health and illness is also unequally distributed among the population of 47 million. 5.5 million of these are living with HIV, the highest number in the world. 55 percent of the 5.5 million are women of lower socioeconomic status, mostly from the African part of the population between the ages of 20 and 29 (UNAIDS, 2007, Connolly et al, 2004, South African Gov. 2007). The high prevalence of HIV poses a huge burden on the South African health care system (Lamiraud et al, 2005).

The inequality in South Africa also manifests itself in poverty. The majority of the South African population are living below the poverty line in South Africa. These people are living in different parts of the country, and the majority live in the eastern part in the municipalities of Eastern Cape, Limpopo, the Free State and KwaZulu-Natal. KwaZulu-Natal has the largest poverty gap which is a result of higher population growth compared to economic growth. Poverty in South Africa is also divided unequally between its population groups, where the large African population faces the highest rates of poverty (Human Science Research Council, 2004).

Poverty is one of the main reasons behind homelessness in South Africa. About 3 million people are homeless in South Africa. They are homeless due to various factors, however, poverty is what has lead them into being homeless influenced by years of apartheid policies, a shortage of housing, migration and economic dislocation, and unemployment. Further, social issues like violence, abuse, disruption of families and illness are also factors that influence homelessness in South Africa (Olufemi, 2000).

2.2 South Africa and health care

The inequalities in South Africa have also manifested itself in huge differences when it comes to access to social services, especially health care (McIntyre and Gilson, 2002). With the end

of apartheid in 1994 the focus of the new government lead by the African National Congress (ANC) was to reduce poverty and improve the situation of inequity in the society. The general agreement was to focus on health and health equity to eradicate the legacy of apartheid. The focus of the health care system since 1994 has thus been equity, with a special emphasis on the most vulnerable in society. One of the groups identified as vulnerable by the South African government is women and children (McIntyre and Gilson, 2002).

In South Africa health care is free for children up to 6 years of age and for pregnant women. This was established in 1994 with the dissolve of apartheid. In 1996 primary health care fees were also removed (Burgard, 2004, McIntyre and Gilson, 2002). These cuts of fees in the health care system were part of the agenda to reduce the inequalities in the society created through years of segregation during the period of apartheid (Schneider and Gilson, 1999, Myburg et al, 2005). Nevertheless, there are still huge inequalities when it comes to access to health care among the South African population, a picture which partly can be blamed on the policies of apartheid and partly from badly managed distribution on financial means with the South African government and health care system (McIntyre and Gilson 2002, Schneider and Gilson, 1999). Some legacies of apartheid are still present in todays health care system however, with over half of the expenditure on health care still allocated to the private health care section and the majority of physicians also working in the private sector (Benatar, 2004, Kon and Lackan, 2008).

As part of their agenda to create a equitable health care system, it was reconstructed into a district health care system (DHC) based on the principles of primary health care (PHC). The health care system is divided into equal geographical areas, which are responsible for providing health care to its population based on the principles of primary health care (PHC) (South African Government, 1997). The responsibility of the system is divided between a national, provincial and a district level, with the national level providing the leadership for implementation and running of the system (South African Government, 1997). The reason behind creating a district health care system was that it offers the best possible system to provide equitable health care to the South African population. To further assure this goal there is also a focus on merging the public and private sectors of the health care system, which is the responsibility of the district level of the system (South African Government, 1997).

Today however, there are still huge differences between the public and the private sectors of health care in South Africa. The private sector serves 20 percent of the population, the ones who has health insurance, with 60 percent of the 9 percent spent on health care from the nation's GDP. Also, the private sector employs 66 percent of the country's health care work force. This leaves the public sector with 37 percent of the work force and 40 percent of the allocations from the GDP, which is

supposed to serve 80 percent of the population (Benatar, 2004).

2.3 Young homeless mothers and access to health care

The majority of homeless individuals in the world are women and their children. In South Africa four out ten homeless individuals are women (Olufemi, 2000). Youth who are homeless face several threats to their health, and is considered vulnerable for negative health outcomes. The most common health concerns are STDs, HIV, acute and chronic respiratory diseases, mental health and substance abuse (Ensign 2004, Ensign and Bell, 2004). Despite this fact it has been shown that this population group lacks access to health care services (Haldenby et al, 2007). To improve this situation it is vital that we learn more about how this population views health and about their experiences with health care (Haldenby et al, 2007).

In Durban homeless youth get help with various issues from an organization called Umthombo. One of these issues is access to health care. Umthombo is an organization that is by and for street children in Durban. They work closely with children and adolescents who live on the street. Their aim is to empower homeless kids to get of the streets, and to help them see that they can have a different and better life (Umthombo, 2008). One group they work with is young homeless mothers living with HIV and AIDS. The researcher first met with a representative for Umthombo in 2007. There was then a concern that young homeless mothers had no or very limited access to health care. That conversation lead to this research project, and it is these young homeless mothers who are the focus of this study.

3. Existing research

3.1 Overview of literature

This is a study on young homeless mothers and their access to and utilization of health care in Durban, South Africa. To gain knowledge on this topic it has been useful to look at related themes and other studies that center around homeless youth, health related behavior and access to health care. Existent research on the topic of youth, homelessness and health discuss issues like the effect of homelessness on health, access to health care for homeless youth, the role of health care providers, and barriers to health care for homeless youth. Here we will provide an overview over existent research on these topics and also look at the need for further research.

3.1.1 Homeless youth and health

Being homeless poses risks to a persons health. This is something that has been well documented in several studies (Ensign and Panke, 2002, Haldenby et al, 2007, Hudson et al, 2008, Kushel et al, 2001, Olufemi, 2000, Solorio et al, 2006). Common health issues among homeless youth are sexually transmitted infections (STIs), mental illness, respiratory diseases and substance abuse (Ensign and Panke, 2002, Hudson et al, 2008, Kushel et al, 2001, Solorio et al, 2006). The high risk and the high prevalence of these health issues is caused by the environment and conditions that homeless youth live under, like poor hygiene, violence and sexual abuse, survival sex, lack of stable housing, and low levels of nutrition (Hudson et al, 2008).

Homeless youth are also at high risk for HIV infection, and in North America the chances of contracting the infection is 6 to 12 times higher among homeless youth than with the average youth population (Haldenby et al, 2007). The group in South Africa with the highest risk for HIV is young vulnerable women, of lower socioeconomic status, of the black part of the population. There is also a higher risk for HIV in urban compared to rural areas, and in informal compared to formal settlements (Connolly et al, 2004).

Despite the high level of health burdens amongst young homeless, they are amongst the population with the lowest access to health care (Ensign and Panke, 2002, Haldenby et al, 2007). This issue is one of the arguments supporting the need to establish more knowledge on the

perceptions of and experiences with health of young homeless to be able to improve the situation of access to health care (Haldenby et al, 2007).

There are several studies who have looked at the issue of how homeless people, young and old, perceive health care and health care workers, and how this affects health seeking behavior in terms of seeking help at a health care facility. Hudson et al (2008) contributes the poor health status of homeless youth partly to the distrust that exists towards health care workers. This distrust leads to a lack of willingness to seek health care on the homeless youth's behalf, which leads to a poorer health status than average youth who use health care on a regular basis (Hudson et al, 2008).

3.1.2 Access to health care

Studies that have looked at health related behavior of homeless youth have found that they tend to use emergency care as their primary health care service (Ensign, 2004, Ensign and Bell, 2004, Ensign and Gittelson, 1998, Solorio et al, 2006). Lack of access to primary health care and a regular source of care were most often the reasons why homeless youth use emergency care as their primary health care facility (Ensign and Bell, 2004, Ensign and Gittelsohn, 1998).

Studies on access to health care also focus on the agency of homeless youth, and how and why they access health care services. In their study on homeless youth in Baltimore Ensign and Gittelsohn (1998) found that the participants were surviving under difficult circumstances through negotiating their way through life based on their strengths and experiences. In terms of health seeking behavior they sought health care with different types of health care facilities, like the emergency rooms, different hospital clinics, mall-clinics and health department-clinics. The different types of clinics where used according to what type of health related issue they needed help with. They knew where to go and where they would receive the most appropriate help based on their experience of being perceived as homeless and their experience with the various health care facilities (Ensign and Gittelsohn, 1998).

3.1.3 Barriers to health care

The literature on barriers to health care for homeless youth discusses several issues that make it difficult to access and utilize health care. The most common barriers defined by homeless youth themselves are lack of insurance, transportation problems, and judgment and discrimination from staff (Ensign and Panke, 2002, Hudson et al, 2008).

Poor treatment by staff is something that has been discussed as a barrier to health care for homeless youth and other vulnerable populations in several studies. Hudson et al (2008) did a qualitative study in California, USA, and found that the treatment the youth received from health care staff had a crucial impact on their willingness to seek health care, and as a result of this it would ultimately have a negative effect on their health status (Hudson et al, 2008).

Ensign and Panke (2002) also did a qualitative study where they found that one of the main barriers to health care for homeless youth was judgment from health care workers and a lack of respect for their knowledge own health status. The participants in this study were all female and expressed a desire for health care workers to treat them with respect and talk to them like they are equals. They argue that health care providers have to be sensitive to the needs of homeless youth in how they want to be treated to create a better atmosphere of health care for this population (Ensign and Panke, 2002).

3.1.4 Sources of care

In studies on homeless youth and health related behavior it has been shown that homeless youth often keep some form of contact with family or relatives after they become homeless, and that one of the reasons for this is that they are a source of care and advice in relation to health (Zerger et al, 2008, Ensign and Gittelsohn, 1998, Ensign and Panke, 2001).

Another source of care can be found in health care workers. Several studies have pointed out the importance of the role of the health care worker in relation to health seeking behavior of homeless youth (Ensign and Panke, 2001). What is found to be critical for improving access to and utilization of health care services for homeless youth is health care workers who listen, are honest, respecting and non-judging (Zerger et al, 2008, Ensign and Panke, 2001).

3.1.5 South Africa and homelessness

Most of the studies performed on homeless youth and health are from North America. There is a general lack of knowledge on issues of homelessness in South Africa, and particularly homeless youth. We are only aware of a few studies performed on homeless mothers from South Africa. Olufemi (1999) did a study on homeless women in Johannesburg on their health. He looked at different diseases and illnesses among the women, and their access to health care, and all data was based on the individual experiences of the homeless women. He found that poor living environment was the main cause of their poor health status.

Olufemi (2000) also did a study on homeless women in Johannesburg with focus on poverty and homelessness. He looked at their socioeconomic characteristics and found that the majority of the homeless women were between 20 and 40 years of age, unemployed, have low or no education, have low or no income and are of African origin. Olufemi discusses how causes of poverty among the homeless women can be connected to their state of homelessness. Poverty in South Africa is mainly caused by the inequalities in the country, partially as a result of years of apartheid policies, and these inequalities are also what have forced people in South Africa into homelessness. In other words, it is underlying structural issues like economic, social and political policies that causes, and are still causing poverty and homelessness in South Africa (Olufemi, 2000). Finally, Olufemi argues that homeless women in South Africa are able women who could contribute to society rather than being a burden if they got the appropriate help. He also says that the women should be included in actions done to help them for the interventions to be successful (Olufemi, 2000).

Another issue that is closely connected to homelessness and youth in South Africa is HIV and AIDS. Swart-Kruger and Richter (1997) have done a study on AIDS-related knowledge and attitudes among male street youth in South Africa. They found that HIV and AIDS were not among the top priorities of the street youth as other more immediate needs like food and money were more important for everyday life. Nevertheless, street youth often put themselves at risk for HIV and AIDS through sexual practices, which are influenced by the economic and social circumstances they live under, and the circumstances that lead them to become homeless in the first place. The study shows how AIDS, and health, is influenced by and deeply rooted in social surroundings, and that this needs to be recognized to improve the situation (Swart-Kruger and Richter, 1997).

There are also studies on homeless youth and health from other developing countries. One study from Pakistan looked at street children's perceptions of health and barriers to utilization of health care (Ali and Muynck, 2005). They argue that associations of health often depends on the context of homelessness, and found that health was viewed in the light of the street children's everyday life, which consisted of working the whole day to make money to survive. Health to them was a state that allowed them to work and illness was something that prevented them from it (Ali and Muynck, 2005).

3.1.6 Gaps in knowledge

The majority of existing research on homeless youth and access to health care is from developing countries, specifically North America. The studies performed there conclude with a need for further research on homeless female youth and their health seeking behavior and what they

perceive as barriers to health care (Ensign and Gittelson, 1998, Ensign and Panke, 2001). There is also a lack of research on young homeless mothers, specifically on the issue of homelessness and motherhood.

There is a lack on research on homeless youth and health in developing countries, where only a few studies have been conducted to our knowledge. A few studies have been done on homeless women in South Africa, however, more knowledge is needed on homeless young women and mothers, their perspectives and experiences with health and access to health care.

The majority of studies done on homeless youth are focused on their vulnerability and lack of resources. However, the focus of research has also shifted somewhat recently to look at resilience factors of homeless youth and how they cope with their surroundings in terms of health care, rather than just looking at them as a vulnerable population (Zerger et al, 2008). More research is needed with this focus.

3.2 Conceptual framework

This is a concept-based study. The main objective for this study was to identify perceived access to health care for young homeless mothers in Durban, South Africa. To do this we first have to clarify some of the concepts that we have used in this study. We will clarify the following concepts; homeless, equity of access, access, utilization and quality. We will also discuss how these concepts have been used in this study.

3.2.1 Homeless

To describe what homelessness is can be very difficult, as numerous definitions of the concept exists (UNCHS, 2000). According to UNCHS (2000) what homelessness means depends on what part of the world one is in, what kind of context it is being used in, and what time-perspective one uses. They mention several groups who have been labeled as homeless which can vary from 'rough sleepers', 'pavement dwellers' and 'street children' to 'occupants of shelters', 'occupants of unserviced housing', 'sharers' and even 'occupants of mobile homes' (UNCHS, 2000). However, the report suggests a possible way to describe homelessness, which is 'not having an adequate level of housing provision' where adequate depends on what is accepted in a specific

context or culture (UNCHS, 2000).

Further, there is also a difference if one defines homelessness narrowly or more widely, with a narrow definition being 'roofless', 'houseless' or living in inadequate housing, and a wider definition being living in intolerable housing conditions like overcrowded housing, forced sharing or living conditions with high levels of noise and pollution (UNCHS, 2000). Nevertheless, the fact that 'to be homeless' can have various meanings creates difficulties when wanting to get an overview of a homeless population within a society (Haldenby et al, 2007). The definition of homelessness also tends to vary according to context, which is also true for the experience of being young and homeless, especially when it comes to health. This could make it difficult to make generalizations about homeless youth and health (Haldenby et al, 2007).

According to the South African High Court 'homelessness' is being without a home or shelter, as they separate three groups of people; those who live in a house, those who live in a shelter, and those who are homeless (UNCHS, 2000). However, there are other definitions of homelessness in South Africa that also include people who live in shelters and shacks, either in informal settlements or in townships. Olufemi differentiates between people who live on the street and 'those occupying poor quality housing in squatter settlements' (UNCHS, 2000). Further he defines homeless people in South Africa as 'those who lack real homes; live in bad housing; sleep on pavements; lack basic needs (with no access to safe water, sanitation) and lack personal needs (self-determination creativity, dignity, expression and voice)' (Olufemi, 2000). That South Africa uses different definitions of homelessness creates a large homeless population in the country, and Olufemi estimates the number to be 3 million homeless people and 8 million people who live in shacks (Olufemi, 2000).

When discussion homelessness is it also common to divide the concept into different categories. Some differentiate between 'literally homeless' and 'marginally homeless'. Literally homelessness incorporates those who live on the streets or in shelters, and marginally homelessness defines those who live with friends or relatives, or in transitional housing and hotels (Kushel et al, 2001). Others view homelessness as part of a continuum, like Cooper (UNCHS, 2006) has done with his four categories of homelessness. The categories are 'absolute homelessness', 'first degree relative homelessness', 'second degree relative homelessness' and 'third degree relative homelessness/ inadequate housing/ incipient homelessness'. This continuum goes from absolute which is not having an acceptable roof over ones head, to third degree homelessness, which is living in a house which can not be defined as a home due to lack of safety and security (UNCHS, 2006).

The reasons that lead to homelessness amongst youth is also discussed in the literature on homelessness. There are several reasons for why someone becomes homeless, however the most

common reasons for homelessness for youth and adolescents are abuse, physical or mental, family conflict, parental substances abuse, poverty, and HIV and AIDS (Haldenby et al, 2007, Hudson et al, 2008, Olufemi, 1999).

In this study we have defined homelessness as either living on the streets, in shelters or abandoned buildings or people who sometimes live with relatives. This way of defining homelessness correlates with Coopers' four categories of homelessness, where young mothers living on the streets are absolute homeless, young mothers living in shelters or abandoned buildings, and young mothers who sometimes stay with relatives for brief periods are first degree relative homeless, which Cooper defines as people who move between different forms of temporary housing, like shelters or living with friends, in this study being relatives (UNCHS, 2000).

3.2.2 Equity of access

Equity of access is a concept that many health care systems all over the world strive to create and uphold (Goddard and Smith, 2001). However, what equity of access entails is not always clear, and many studies fail to define it, which makes it difficult to draw concrete lessons from them (Goddard and Smith, 2001, Oliver and Mossialos, 2004).

There are in essence two types of equity; horizontal equity and vertical equity. Horizontal equity is the concept used when we talk about that people with equal need for health care also have equal opportunities to act on this need in terms of access to health care (Oliver and Mossialos, 2004). Horizontal equity has tended to be the focus of most health care systems with emphasis on universal access to health care (McIntyre and Gilson, 2002).

Vertical equity is the term used when we have people with unequal need for health care who also have an unequal opportunity to access health care (Oliver and Mossialos, 2004). It has been argued that vertical equity should be the goal in societies with large inequalities in health status (McIntyre and Gilson, 2002). This is because the unequal opportunity of accessing health care is distributed unequally between different groups in society and most commonly the best access belongs to the groups that are best off. To correct this unequal distribution of access, and create an equitable distribution, the best access should belong to the groups with lowest health status in society (McIntyre and Gilson, 2002). Vertical equity thus entails that access to health care should be distributed according to socioeconomic and health status, from bottom to top.

The South African government committed itself in 1994 to tackle the immense inequalities created by the apartheid era, with a special emphasis on health care. One of their main priorities was

to reach the most vulnerable groups of society, and thus the notion of vertical equity would best fit their political agenda for the health care system (McIntyre and Gilson, 2002). This necessitated a focus on primary health care as it is what is most accessible to the general population in a society, also in South Africa (McIntyre and Gilson, 2002).

When we discuss access to health care for young homeless mothers in Durban, South Africa, we will base this discussion on the concept of vertical equity. This is because, as explained above, the South African government has prioritized the most vulnerable segments of their population when improving the situation of access to health care in South Africa, which implies that they should also use vertical equity.

3.2.3 Access and utilization

According to UNICEF the definition for access to health care is 'Percentage of the population that can reach appropriate local health services by the local means of transport in no more than one hour' (UNICEF, 1996). This definition focuses on distance and transport to health care as a measure of access, which can be problematic because they are often not the only issues that influence access to health care. In this study distance to health care services and means of transport were not very relevant issues due to short distance to health care facilities, and thus this definition of access will not be used.

Access is a concept that has been used with various meanings and one universal definition is hard to come by. There is a substantial amount on literature on what access means, and with it several different opinions on how it should be used. The different uses of the concept have resulted in difficulties when creating policies to improve access to health care (Oliver and Mossialos, 2004). It is therefore important to be clear about how one uses the concept so any recommendations can be understood from a known point of view. I will here present a few of the suggested meanings of access, and then give a rational of the way access has been used in this study.

Access to health care can have three meanings according to Gulliford et al (2002) in their article 'What does 'access to health care' mean?'. Broadly they differentiate between measuring access in terms of having it, utilizing it and what the outcome of the access is. The first one is that access to health care means having the possibility to gain entry to a service if you need it. The second one is that access means being able to not just enter into a health care service but also use the services they provide. The third possible meaning of access to health care is focused on the

outcome of health care, namely if a person's health benefits from using the service or not (Gulliford et al, 2002).

O'Donnell (2007) also suggests three different ways of defining access in his article on 'Access to health care in developing countries: breaking down the demand side barriers'. The first one is geographical availability; if there are available health care services within a certain geographical area. The next is a bit more profound and says that access consists of four dimensions; availability, accessibility, affordability and acceptability. Is the health care available, can it be accessed, is financial means an issue and is the health care accepted by its potential users. The last one defines access as the use of health care. This definition does not distinguish between physical access and utilization of access (O'Donnell, 2007).

Although there has been some disagreement on one definition of access when talking about health care, there is some consensus around that access in terms of having it and access in terms of using services should be separated. This means that access to health care is not the same as utilization of health care (Oliver and Mossialos, 2004, Gulliford et al, 2002, Goddard and Smith, 2001). To have access to a health care facility does not mean that one is able to take advantage of the services that they offer or that they are given to everyone who seeks them on an equal basis (Gulliford et al 2002, Oliver and Mossialos, 2004).

Another issue when it comes to what access means is context. It has been argued that context has to be taken into consideration when talking about access (Goddard and Smith, 2001). To do this a general definition of access is used; 'the ability to secure a specified set of health care services, at a specified level of quality, subject to a specified maximum level of personal inconvenience and cost, while in possession of a specified amount of information'. When the definition is as general as this one, access can be adjusted to a specific context. When comparing access between developed and developing countries a general definition is good as the level of health care and the level of resources are different, and thus the level of access will also be different (Oliver and Mossialos, 2004).

In this study we have looked at access in terms of entering a health care facility and access in terms of utilization of a health care service. Access will throughout this study refer to having the possibility to enter into a health care facility. It also includes the waiting time before the actual medical attention is initiated. Utilization will refer to the actual usage of a health care service. This could be seeing a health care professional, receiving medications and health care, and being admitted to a hospital. We have chosen to differentiate between access and utilization because the problems the participants in this study experiences could be divided between the two.

3.2.4 Barriers to health care; supply and demand

A barrier can be defined as an obstacle or a hinder to give or receive something. Barriers is an important issue in the literature on accessing health care, however how barriers are labeled in the literature varies. Some of the different labels that are most common will be presented here.

The most common way of discussing barriers is to divide them in two; supply and demand barriers (Ensor and Cooper, 2004, McNamee et al, 2009, O'Donnell 2007, Oliver and Mossialos, 2004). When talking about supply barriers we talk about barriers or obstacles for the health care system to supply or provide health care to the population. Examples of supply barriers could be lack of resources, staff-shortage that results in long waiting hours, lack of medicines and poor service level with health care personnel (Ensor and Cooper, 2004, Oliver and Mossialos, 2004, McNamee et al, 2009, O'Donnell, 2007).

Something that affects the demand for access to health care at an individual, household or community level can be considered a demand barrier (Ensor and Cooper, 2004). Issues that influence demand could be lack of information about available health care, high costs of health care, lack of awareness of disease and illness and lack of willingness to use available health care (Ensor and Cooper, 2004).

Another way of discussing barriers is to divide them into personal, financial and organizational barriers like Pechansky and Thomas have done with their approach to access (Gulliford et al, 2002). They define personal barriers as lack of recognition of need of health care, attitudes and beliefs about health care and previous experiences with health care. A patient has to perceive a need for health care and also have a certain level of good impressions with health care to choose to use it. Financial barriers are costs or charges that are made to access health care or other costs like travel and time for work lost. How much it costs to access health care depends on your socioeconomic status, and financial barriers tend to be a more important issue for people of low socioeconomic status than for people with high socioeconomic status. The organizational barriers are the difficulties of delivering efficient health care to a population, like long waiting hours and bad use of resources (Gulliford et al, 2002).

As explained above, in this study we look at access and utilization. We have also chosen to use the concepts of supply barriers and demand barriers as they allow inclusion of the findings on this subject in this study.

When it comes to access we usually talk about supply barriers, however, with utilization we talk about both supply and demand barriers (Gulliford et al, 2002). This holds true when we look at

equal access for people with equal need, as access is then a question of making health care available for people with equal need for them (Goddard and Smith, 2001). In this study we looked at a specific population group among homeless youth; young homeless mothers. It was assumed that based on their similarities of being young, female, homeless mothers living in the same area under more or less equal conditions, they would have somewhat similar health needs and concerns. With this assumption of equal need we can discuss equal access for this particular population, and thus we have also chosen to look at access in relation to supply barriers and utilization as a combination of supply and demand barriers. Utilization is often an issue that is influenced by the interaction of supply and demand; if a person actually receives care depends on if the care is supplied and if it is a demand for it (Goddard and Smith, 2001).

When it comes to actual interventions to improve the situation of health care, there is a tendency to focus of supply barriers and how to reduce them (Ensor and Cooper, 2004, Oliver and Mossialos, 2004). However, several studies have shown that it is equally, if not more important to look at demand barriers to improve access to and utilization of health care. Demand barriers are particularly important barriers to health care for vulnerable segments of the population as lack of information and ability to pay are often bigger barriers for people of lower socioeconomic status than for people with higher socioeconomic status (Ensor and Cooper, 2004, Oliver and Mossialos, 2004).

The literature on barriers to health care emphasizes the importance of understanding how barriers work when people are trying to access health care. To improve the situation of low access to health care for the populations in most need, we need to increase the knowledge of what keeps them from attaining good health (McNamee et al, 2009).

In this study we will differentiate between supply and demand barriers when we present our findings. However, as will be discussed later, supply and demand barriers are often connected and dependent on each other, and so it is not always easy to separate the two. As we will see with this study, supply and demand barriers to health care for our participants are connected through perceived quality of care, which is the next concept we will clarify.

3.2.5 Quality

Barriers to access and utilization of health care is not sufficient to look at when wanting to improve the health care situation for young homeless mothers. One also has to look at the quality of the health care that they are getting (McNamee et al, 2009). The quality of health care has been

shown to be connected to the demand for health care, which again is connected to access and utilization of health care, so quality, and improvement of quality, is an important issue in this study (O'Donnell, 2007).

When it comes to quality in health care it can be judged based on several issues; environment and surroundings, availability of resources, availability of staff and treatment of patients (McIntyre and Gilson, 2002). How quality of care is defined also differs. Here we will look at some of the different ways it has been defined.

Traditionally, quality of care has been defined based on 'clinical quality' (Lawthers et al, 2003). This definition comes out of the medical model of care and describes quality of care as 'doing the right thing, in the right manner, and achieving the right outcomes' (Lawthers et al, 2003). This definition has a overhanging technological view where the main focus is prevention, diagnosis and treatment, and not the patients preferences (Lawthers et al, 2003). However, the patients preferences has become more important over the years, and with the US Institute of Medicine's definition of quality of care, it was included as a vital part of quality of care. They define quality as 'the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge' (Lawthers et al, 2000).

A more comprehensive definition of quality comes from Campbell et al (2000). They propose two different definitions of 'quality of care' based on whether it is quality of care for individuals or quality of care for populations. Quality of care for individuals is defined with 'their ability to access effective care with the aim of maximizing health benefit in relation to need' (Campbell et al, 2000). This definition is based on that quality of care consists of two dimensions; access and effectiveness. Access is basically if patients get care when they need it. Effectiveness is if the care received is effective; that is does produce the desired outcome or process in connection with what was needed (Campbell et al, 2000). Effective care is further dependent on the individual's perception of illness and if the health care worker incorporates this and other circumstances that are specific to the individual into the process of care (Campbell et al, 2000).

Quality of care for populations is defined as 'the ability to access effective care on an efficient and equitable basis for the optimization of health benefit/ well-being for the whole population'. In addition to access and effectiveness, quality of care for populations is also dependent on equity, efficiency and cost. Access is here based on whether the whole population is able to access health care based on wither horizontal or vertical equity. Horizontal equity is as defined earlier equal access for all, and vertical equity is unequal access for people with unequal need where those who need it most should have the greatest access. Effectiveness is also connected to equity, as

the desired situation is that the whole population should have the same level of efficiency of care. However, as this is not probable scenario, distribution of resources in relation to effective care could rather be based on who needs the best effective care. This decision is for the society to make (Campbell et al, 2000).

Their argument is however that 'quality of care' should be defined based on individuals rather than populations as care is received on an individual basis. However, the individually received care has to be viewed based on a societal context, as the individual is part of a population, which constructs how he or she perceives health care and the health care system (Campbell et al, 2000).

Based on their view of quality of care Campbell et al (2000) also lay out what influences it for the individual. They argue that health care, and what it consists of, both directly and indirectly influence quality of care. Health care is both the health care system and what happens within it that effects the health or well being of a person (Campbell et al, 2000). The care that an individual can receive from health care is divided into structure, process and outcome.

Structure is the organizational factors that make up the health care system, like personnel, equipment and buildings. Process is the contact between the individual and the health care system and involves what happens when care is delivered and received. There are normally two types of processes; technical interventions or clinical care which refers to the actual delivery of medications, and inter-personal interactions which refers to the interplay between patient and health care worker. In order to produce good inter-personal interactions the health care worker has to possess skills in communication, establishing trust and the ability to show understanding and empathy for the patient. Outcome is what happens as a result of the care received. It is influenced by both structure and process. The outcome can be the health status of a person and the contentment of the patient in relation to the care received. The contentment of the patient is related to the need for health care and the expectations to health care. It can either refer to the health status after ended care or to the process, which could be how they were treated by health care personnel (Campbell et al, 2000).

There are conflicting opinions on whether it is the outcome or the process that should be the measure for quality of care. Campbell et al argue that process is often a better measure if the intention is to improve the 'behavior of the health care system', that is how the patient is treated. The process is also easier to influence as it is the health care workers who control it. The outcome could be difficult to measure as it is often related to more than just treatment within the health care system (Campbell et al, 2000). In our study the quality of care is also measured by the process of health care as the participants mainly judged quality on how they were treated by the health care personnel, and if they got what they expected, which is here the inter-personal interaction part of the

process. The outcome of health care was not explored in this study as it was beyond the scope of the study.

The quality of health care in this study was judged by the participants based on how they were treated, and if they got what they wanted when they sought help at a health care facility. When we view quality from the patients' point of view, based on their experiences, we call it service quality (Weingart et al, 2005), which is similar to the inter-personal interaction segment of Campbell et al's (2007) definition of quality of care. Service quality is assessed through talking to patients about their experiences regarding received health care (Weingart et al, 2005). Thus, quality of care is in this study based our participants' perceptions of treatment received by health care workers.

4. Objectives

4.1 General objective

- Identify perceived access to health care by young homeless mothers in Durban, South Africa

4.2 Specific objectives

- Explore how young homeless mothers in Durban perceive health, and if being a young homeless mother influences the perception of health
- Assess utilization of health care for young homeless mothers in Durban, South Africa
- Identify barriers to health care defined by young homeless mothers themselves
- Assess quality of health care for young homeless mothers in Durban, South Africa
- Identify how access to and quality of health care by young homeless mothers living with HIV and AIDS in Durban, South Africa, can improve

5. Methodology

5.1 Frame of Study

The aim of this study was to look at access to health care for young homeless mothers living in Durban, South Africa. In this we wanted to seek to understand how young homeless mothers view health, how they experience health care, and if they think differently about health after having children. In other words, we wanted an understanding of their health related behavior. Based on this objective we chose to use qualitative methods for this study. Other studies have shown that qualitative methods are good in describing people's experiences when trying to identify problems and issues related to health (Ensign, 2003, Ensign and Bell, 2004). Qualitative methods were also chosen for this study due to their ability to contextualize experiences, and for their ability to bring out personal experiences (Milligan et al, 2002).

5.1.1 Time and place

The study took place in Durban, South Africa from the 15th of August to the 15th of December. South Africa lies on the southern tip of Africa, and is amongst the most developed countries in the region. It has about 47 million inhabitants, and has 11 official languages. Durban in the second largest city in South Africa, and has approximately 3.2 million inhabitants. It is situated in the KwaZulu-Natal province, on the east coast. It is a center for high concentration of people living with HIV and AIDS (Abdool Karim & Abdool Karim, 2005). According to the UNAIDS epidemic update of 2007, KwaZulu-Natal was the province in South Africa with the highest prevalence of HIV (UNAIDS, 2007).

5.1.2 Population

The study population was a group of young homeless mothers living in Durban, South Africa. This population consists of largely black women within the ages of 15 to 25 years. It has been shown that it is young black women in urban areas of lower socioeconomic status are amongst

the population who have the poorest access to health care in South Africa (Ntuli et al, 2003). All the participants in the study were young black women who spoke isiZulu.

5.1.3 Inclusion and exclusion criteria

Young mothers between the ages of 16 to 25 were participants in the study. The standard numbers used when defining 'young' as a concept by WHO is 15 to 24. However, Norwegian legislation states that 16 is the lower age limit for research subjects themselves deciding to participate in a research project, and thus this was the lowest age limit as well. Further, women who had one or more children of any age were included in the study. Some of the mothers had their child or children living with them, but the majority of the children were either living with relatives outside of the city or they were deceased.

Women who either lived on the streets, in shelters or abandoned buildings or people who sometimes lived with relatives where included in the study. Some of the women were absolute homeless, that is they were living on the street, however most of the participants where relatively homeless. This included the women living in shelters or abandoned buildings and some of the women living on the streets who on occasion lived with relatives in and around Durban. The participants had to be currently homeless or have been homeless during the past year.

Originally we wanted to look at women or mothers who knew their HIV status. However, after some preliminary observation and conversations with the research assistant, it was decided that HIV was to be discussed if the issue came up during interviews or focus groups, and that it would not be a requirement that they know their HIV status to be a part of the study. HIV and AIDS is only one of many health issues for young homeless mothers in Durban, and so it was decided that it should not be the main focus of the study.

5.1.4 Sample size

Eleven young homeless mothers were interviewed over a period of two months. Six of these also participated in two focus groups at the end of the fieldwork. Six staff-members at Umthombo were also interviewed, and four of these participated in a focus group.

5.1.5 Recruitment

Research participants were selected on the basis of convenience sampling (Green and Thorogood, 2004). People who had knowledge and experience with the topic of the study were invited to participate, in addition to young homeless mothers in Durban, South Africa. All the young homeless mothers who participated were selected on a random basis; who ever we found on the street on one particular day that who wanted to participate, and who fit the inclusion criteria were invited to participate. However, all the participants were in one form or another connected to Umthombo, either through daily contact or less regular contact.

Young homeless mothers are part of a population that is considered hard to reach in terms of research. When performing research with 'hard-to-reach' groups, there are several methods you can use. Recruitment can happen via personal contacts, via advertising, or via community groups (Green and Thorogood, 2004). In this study we used a contact in an organization that work with homeless youth to recruit participants. Recruiting research participants through an intermediate can produce biased results, however, as young homeless mothers in Durban can be hard to reach, recruitment via an intermediate that know the environment is often a good method to get valid results. Further, when participants are recruited this way they might not be representative for the whole population-group (Green and Thorogood, 2004, Amuyunzu-Nyamongo, 2007). Therefore it is important to acknowledge this weakness when recruiting participants through a third-party.

On the first day of observation, oral explanation was given to potential participants. Before initiating interviews and focus groups both oral and written explanation of the study and what it entailed to participate was given to the participants, regardless of previous provision of the same information.

5.1.6 Refusals and missed opportunities

5.1.6.1 Ethical Clearance

Ethical clearance was obtained from the Ethical Research Committee at Edgewood Campus of the University of KwaZulu-Natal. According to the National Health Act No61.2003 ethical approval from a committee that is registered with the Department of Health is a requirement to conduct research in South Africa. The ethical research committee at Edgewood is registered with

the Department of Health. Ethical clearance was also obtained from the regional committee of medical research ethics at the University of Oslo before the initiation of the fieldwork.

Due to some different opinions from various people that were contacted regarding ethical clearance, the application for ethical clearance was only handed in late in September 2008. The differences in opinions altered between that approval was only needed from the organization that participants were recruited from and potential health service institutions to full ethical clearance from a ethical research committee. These differences in opinion delayed the actual application. Then an additional month went by before the project was approved by the Ethical Research Committee at Edgewood Campus. Fieldwork was thus only initiated as of November 1st.

5.1.6.2 Refusals

There were no refusals to participate in this study amongst the participants we approached. One possible reason for this is that all participants approached were in some manner connected to the organization the research assistant worked with. The weakness of this will be discussed later in this paper. However, the impression was that the participants we approached seemed happy to participate and share their stories after full disclosure of what it entailed to be a part of the study.

There were a few potential participants we were not able to interview because they had went home or somewhere out of the city by the time we received ethical clearance. One potential participant had left to give birth to her baby.

5.1.6.3 Health workers

One of the groups of people that is important to involve to get a thorough understanding of young homeless mothers health need and their access to care was health workers. During interviews and observation it became obvious that the homeless mothers mostly used health care services at a large health care facility in downtown Durban. Contact with the appropriate people at this facility was sought several times, by visiting, by phone and by email. The answer received was that they could not allow any health workers to participate in this study during working hours because they were too busy. Certain documentation was also needed for the study to be approved at the hospital which there was a long waiting period for. The hospital administration insisted that the rejection given had nothing to do with the quality or topic of the study, but that it was based on time-constraints. The researcher has full understanding for the time-constraints of the staff at this hospital after seeing how many patients they serve on a daily basis, nevertheless the health workers views on

and experiences with young homeless mothers would have been valuable for this study.

Some of the loss of perspective by not talking to health workers in this study was saved by the inclusion of staff members at a local NGO called Umthombo. This is an organization by and for street children and youth in South Africa with its main base in Durban.

5.1.6.4 Influence of substances

There were some missed opportunities for interviewing possible participants among young homeless mothers because they were under the influence of different substances at the time of the interview. The most common substance they used was glue. They put the glue in plastic bottles or paper-cartons and inhale the fumes of the glue. This makes a person somewhat indifferent to his or her surroundings, and it becomes very difficult to have a meaningful conversation with that person. On occasions possible participants were also under influence of alcohol.

5.2 Gaining access to the field

5.2.1 Locating Umthombo

The organization Umthombo was located on the internet during the researcher's first stay in South Africa in 2007. Umthombo is a NGO that is by and for street children in Durban. They work closely with children and adolescents who live on the street. Their aim is to empower homeless kids to get of the streets, and to help them see that they can have a different and better life (www.umthombo.org, 2008). One group they work with is young homeless mothers. These mothers have no or very limited access to health care. It is these mothers who are the focus of this study.

5.2.2 Translation

All the questions in the interview guide and for the focus group indented to be used when talking to young homeless mothers where translated from English to isiZulu, and then from isiZulu to English by a professional translator at Edgewood Campus of UKZN. The information letter went through the same process. Back- and forth-translation was performed to secure that the intended meaning of the questions and information was maintained. The service of having the material translated was paid for.

5.2.3 The role of the interpreter

The research assistant for this study was an employee with the organization that the researcher was cooperating with to gain access to the field. She had been working with the organization for about three years. She did, as several employees at Umthombo, have a history of homelessness. This was regarded by the researcher as valuable experience with consideration to this particular study in terms of advice and criticism regarding the interview guide and focus group questions.

The responsibilities of the research assistant was to help recruit participants among young homeless mothers in Durban, and also to help conduct interviews and focus groups in isiZulu with the same group. The assistant had no formal education as a research assistant; however, she had valuable experience as she had worked as a research assistant before in a similar project as this one.

She was hired firstly because of her experience and for her unique connection with the target group; young homeless mothers living in Durban. She has lived many years on the street in South Africa, and now she worked for Umthombo in Durban. It was also important to have a female assistant as we assumed that young homeless mothers would be more comfortable talking to a woman than a man about health-related issues.

Secondly, Umthombo has ethical guidelines they have to follow when aiding students in their work with the homeless population. They are quite strict on who they help obtaining access to young homeless people, and prefer if one of their own staff-members assists students in projects like this one. Also, it is their opinion that by having an assistant that knows the environment and situation of young homeless in Durban produces better research than if using someone from the outside.

5.2.4 How we worked together

The research assistant had some experience with qualitative research, however, some basic introduction to what an interview and focus group was and how they are supposed to be conducted was provided.

The research assistant spoke English and isiZulu fluently, however because she lacked formal training to conduct interviews and in interpretation a few choices were made on how the interviews were to be conducted. The researcher began each interview with explaining what the project entailed in English, then the research assistant explained the same information in isiZulu. When the actual interview started, the same pattern was followed; the researcher asked the

questions in English, and then the assistant asked them in isiZulu. Since it was assumed that it could be difficult for the assistant to translate what the participant was saying at the time of the interview with correct interpretation and meaning, it was decided that the assistant would only indicate if the participant gave a positive or negative answer to the question asked, so the researcher could decide if any follow-up questions were necessary.

The questions for both the semi-structured interview guide and the focus group were translated by a member of the isiZulu department at Edgewood Campus of the University of KwaZulu-Natal, and the language used was proper and correct isiZulu. The research assistant was however given some leeway to make the language somewhat more appropriate for the street. She was also allowed to add additional questions that were thought to be important based on the response from the participant.

Each interview and focus group was translated by the assistant and then typed by the researcher. The translation was as close to word by word as possible. After each interview was typed the researcher discussed unclear elements and other issues with the research assistant. The most important issues and unanswered questions were written down and taken up in the two focus groups held with the participants after all the individual interviews were concluded.

5.2.5 Challenges with using an interpreter

When performing a study with an interpreter certain issues emerge that one has to be aware of. There are especially three issues that need to be considered. The first is to establish the level of involvement the interpreter should have in the study. Second, the level of ability of the interpreter has to be considered. And third one needs to take into consideration the possible influence the interpreter might have on the findings of the study (Wallin & Ahlström, 2006).

The interpreter in this study was also the research assistant. This was decided based on the recommendations of a South African NGO that works with homeless youth and thus have experience with what enables good research with this population. The requirements for the interpreter and the research assistant were thus the same. We wanted it to be a female, who spoke isiZulu and English, and who had knowledge of the field. The interpreter/ research assistant was a woman in her late twenties, who spoke isiZulu and English fluently and who had years of experience in the field.

The requirements for the interpreter were based on that it is important to have an interpreter who resemble the study population in terms of gender, age, and ethnicity if it is possible. This is to

lay the foundation for a comfortable setting for the participants during interviews and focus groups (Wallin & Ahlström, 2006).

The level of involvement of the interpreter was high in this study as she was also the research assistant. This was however viewed as valuable involvement as she had knowledge of the field and could contribute in terms of both creating and analyzing the guides for data collection. Her level of ability as an interpreter was limited in terms of education, however her knowledge of the field and how she resembled the participants was viewed as the deciding factor. Lastly, the level of influence the interpreter could have and did have in this study was taken into consideration, however, it was also viewed as valuable influence.

5.3 Data collection techniques

5.3.1 Qualitative methodology

Young homeless mothers in Durban are in the risk group when it comes to poor access to health care services. The aim of this study was to identify access to health care for these mothers. We wanted to look how young homeless mothers think about health, and explore barriers to health care identified by the mothers themselves. If having children has changed how these young homeless mothers think about health was also be explored.

In this study we have chosen to use qualitative methodology. This choice is based on a literature review and several research objectives. In the literature on issues surrounding young homeless women and mothers and access to health care the majority of the studies have used qualitative methods. Many of these studies explain their choice of method based on their overhanging objective; to understand human behavior, not only what people do, but also why and how they act (Green and Thorogood, 2004, Ulin et al, 2005). We wanted to understand the health situation of young homeless mothers, and how and why they access health care.

This study looked at access in terms of access and quality, and based on this explored young homeless mothers experience with the health services. The participants own accounts of what the difficulties are with access, and how it can be improved was also important to obtain. As quantitative methods are limited in explaining and understanding the hows and whys of human behavior, it was decided to take use of qualitative methodology (Green and Thorogood, 2004, Ulin

et al, 2005).

Another justification for the choice of methods is that they are good tools when seeking to understand someone's health related behavior, and are often good in describing people's experiences when trying to identify problems and issues related to health (Ensign, 2003). To explore the particular experiences of young homeless mothers with health care was one of the main objectives of this study.

No quantitative methods were used in this study. One possibility would have been to use a questionnaire to map out issues that could be further explored through qualitative methods (Ulin et al, 2005). However, it was uncertain whether or not the participants were literate and thus qualitative methods where we could sit down and talk to the mothers was assumed to yield better results.

This is a triangulated qualitative study. Three qualitative methods were used; observation, interviews and focus groups. A triangulated study uses two or more methods to make a study as rich as possible. An interview will not necessarily give you all the information you need, however, by including observation and focus groups, more knowledge of the field can be accumulated (Britten, 2006). Also, not all topics are suited for discussion in all settings. We chose to use several methods so all the objectives of the study would have the chance of being addressed, and so that as many perspectives as possible of young homeless mothers could be found (Ulin et al, 2005). Triangulation can also strengthen the study by providing richer data (Malterud, 2001, Patton, 2002).

5.3.2 Observation

Observation was the first method used in this study. It was used as the initial method to get an overview of the field and to allow the researcher to get familiar with the study site. However, as the process to obtain ethical clearance from a committee in South Africa took longer time than anticipated, further observations were conducted during this period.

The first three weeks of the fieldwork was used to accompany various members of the Umthombo staff in their daily tasks. This was done with the intent to get familiar with the organization and the work that they do, and to build up a relationship with the organization and with the possible research assistant.

After some time following various members of Umthombo, observations were limited to

following the member of Umthombo who was chosen to be the most appropriate research assistant for this study. Visits were made to locations where homeless youth tended to hang out to make observations about their living conditions. Observations were also done to get complementary information about who young homeless mothers in Durban were, and to locate possible participants. When ethical clearance was obtained and the process of interviewing could begin, observations continued on a daily basis, but now not only of the field, but also of the participants. Observation was in other words a consecutive process that continued throughout the fieldwork.

5.3.3 Interviews with young homeless mothers

We conducted 11 interviews with young homeless mothers. In nine interviews an interpreter was used. In the two remaining interviews one participant chose to speak English and the other only wanted the researcher present and was ok with conducting the interview in English. All the interviews were semi-structured. An interview guide was followed, but additional questions and other topics were allowed for when they occurred. Nevertheless, all interviews were of similar structure. The interview guide was created based on a literature review done by the researcher before the study was initiated, and revised after consultation with the research assistant. The questions in the interview guide revolved around issues like what health means, the status of the participants health, if becoming a mothers has affected their view on health, what they do and who they prefer to talk to when they feel sick, and how they are treated at a health care clinic. A copy of the interview guide is attached along with the consent form.

The interviews were conducted in different locations. All participants had been given information about the study before the interview by the research assistant. This information was often provided twice as it was given on a day prior to the interview by the research assistant alone and on the actual day by the researcher and the research assistant. Participants were chosen for the study when the researcher and the assistant located them by walking around downtown Durban. The location of the interview therefore depended on where the participants were found, what area of downtown Durban they 'belonged' to, and also on whether or not the participant had a boyfriend and if they allowed for the participant to join the study and participate in an interview.

Consent was obtained before the initiation of the interview, where a witness signed the consent form based on oral consent from the participant. The consent to participate also included focus groups. A digital recorder was used during all interviews and was consented to by all participants. All participants received a meal after the completion of the interview as compensation

for participation. The participants were informed of the compensation after the consent was obtained.

5.3.4 Interviews with Umthombo staff

Six staff-members at Umthombo were interviewed. The interviews were conducted either at the head office of Umthombo in downtown Durban or at the drop-in center located along Victoria Embankment down by the harbor. All interviews with Umthombo staff-members were conducted in English. The participants from Umthombo were staff who was working with young homeless mothers as part of their responsibilities or staff that had been working with the same group previously. All interviews were digitally recorded and consented to after information had been given orally and in written form and before the initiation of the interviews. The consent for participation also included participation in focus groups.

5.3.5 Focus groups with young homeless mothers

Two focus groups were conducted with young homeless mothers. There were five participants in each group, and three of the participants from the first focus group also participated in the second. The participants were chosen based on two criteria in addition to the general criteria for inclusion to the study. The research assistant chose participants among the mothers who were available and could be found on the specific day, and also with consideration to how the young mothers got along, that is, if they could sit in a room together and have a normal conversation. If the assistant thought that one participant would cause disruption to the group she would not be included. Participants under the influence of a substance on the particular day would also be excluded from the focus group.

The focus groups were conducted in a small room in a newly opened center for young homeless under the age of 18 by Umthombo. It had few facilities at the time, so all participants had to sit on the floor or on boxes. The focus group sessions were interrupted on a few occasions due to people coming into the room and when some people were looking through the windows wondering what was going on. This did not seem to have any significant effect on the information given during the session however.

Both focus groups qualified more as group interviews than proper focus groups. The

research assistant was the moderator of the focus groups and the researcher was the observer. Before the focus group began the groups the researcher explained what a focus group was to the participants, and that the intent was for them to discuss the topics or questions that the assistant would bring up amongst themselves. Nevertheless, the focus during the discussion tended to rest upon the assistant. This could be due to the fact that the participants seem to have a profound respect for the assistant, since she is both a former homeless and now working for Umthombo. This issue will be discussed later under limitations of the study.

The themes discussed in the focus groups were based on issues from the individual interviews. Some of the themes were set from the beginning of the fieldwork, and some were developed during data-collection. Most of the questions however were themes that were discussed during individual interviews that we wanted to explore further. Some examples are what it meant to be healthy, what they think about health workers and how they treat them and how important it is to have an ID.

The participants also received compensation for participation with a meal after the completion of the focus groups. This information was given after they information about what they focus group was about, however, the participants might have thought they would receive a meal since they did so after the interviews. Nevertheless, it did not seem to have any affect on the choice to participate.

5.3.6 Focus groups with Umthombo staff

One focus group was conducted with four staff-members at Umthombo. Only four out of the total six participants from Umthombo could join the focus group due to time-consuming schedules. The focus group was held at a small office at the drop-in center along the Victoria Embankment. This was the only place available that was convenient enough for the four participants to participate in the group. The office is not soundproof and there were no enough chairs for all, but they all found a place to sit.

The focus groups were realized under unsatisfactory conditions. Firstly, the researcher had to act as a moderator and observer. The research assistant was a participant in the group because she was an employee with Umthombo, and there was no one to replace her as a moderator at the time. Secondly, the location and space for the focus group was small and not well suited for a focus group discussion. Lastly, the researcher had to ask the participants to discuss in English, something that

had not been a problem during previous interviews, but did however seem to make two of the participants uncomfortable. This assumption is made due to the fact that two of the four participants did most of the talking, while the remaining two only voiced their opinions once or twice.

5.3.7 The process of analyzing data

The process of analyze in this study began when the researcher entered the field. All data collected is thus interpreted based on what the researcher experienced while in the field. The data was collected through observation, interviews and focus groups. The guide for the interview was developed based on a literature review done before the fieldwork was initiated. The guide was edited based on preliminary observations of the field and after consultation with the research assistant. The guide for the focus group was also made before entering the field, however it was edited after observation and discussion with research assistant. Certain themes that emerged with the individual interviews were also implemented into the guide to explore them further.

Each interview was discussed by the researcher and research assistant after it was conducted. This was also done after each focus group. The research assistant provided valuable insights on the meaning of the data based on her background and experience with the field. All the interviews and focus groups were translated and transcribed at the end of the fieldwork before the researcher left the field. The intention was to transcribe each interview and focus group the same day as they were conducted, however, as the research assistant had a full-time job and two children to take care of, her time was restricted, and we were only able to find time to transcribe during the last weeks of the field work.

The data was analyzed manually in this study. After returning from fieldwork, all interviews and focus groups were thoroughly read through. After getting an overview of all the data the interviews and focus groups were read with more precision with the intention to find recurrent issues in the data. We began by categorizing recurrent issues into codes, and then the codes were grouped together into larger themes. Throughout this process, we constantly went back to the transcriptions to make sure that the data was analyzed correctly according to the setting and context of the interview or focus group. Quotes from the transcriptions have been used to illustrate the young homeless mothers perceptions and experiences with access to health care. The quotes have been selected with careful consideration that they are used with the correct meaning. Effort has been made to fairly represent the data and communicate what the data says based on the purpose of the study (Patton, 2002).

5.3.8 Methodological issues

During the course of the data collection it was noticed that some of the participants gave different answers to the same questions when two different techniques were used. We found that some of the participants answered differently on the question about how they were treated when they sought health care from the interview to the focus group.

There could be several possible explanations for this. One is that some of the participants had experienced both good and bad treatment, but had neglected to inform of this during the interviews. Another is that the participants might not have been comfortable enough to talk about the bad experiences during the interview, but felt more at ease when they were in a group of peers who told of similar stories. A third explanation could be that the participants felt pressured to talk about similar stories of bad treatment when in a group of peers during the focus group.

It is more common that sensitive issues are discussed in individual interviews, as it can be difficult to talk about them in the presence of others (Patton, 2002). However, in this case we believe that certain sensitive issues were possibly more difficult to talk about during the individual interviews than in focus groups. This is because the settings for some of the interviews were not optimal. Most of the interviews were conducted in public along the busy road near the beach in Durban. With lots of people watching as they walked by, it is quite possible that the participant felt uncomfortable talking about issues like bad treatment. The lack of privacy in the setting also influenced the researcher. It was more challenging to create an atmosphere were difficult issues could be discussed in this setting than during the focus groups, which were conducted inside.

Another explanation could be that in the setting of the individual interview the participant was one compared to the two 'researchers'; the principal researcher and the research assistant. Both the researcher and the research assistant could be viewed as intimidating from the participant's point of view as the researcher was a white western female and the research assistant was with an organization the participant relied on for help. This could have created a less comfortable situation for discussing sensitive issues than in a focus group where the participants were the majority compared to the 'researchers'. Further, as will be discussed more under ethical concerns, there is also the possibility that the perceived unequal balance of power could influence the participants to answer questions based on how they think the researcher wants them to answer. A focus group would provide the participants with an upper hand as they are form the majority, in addition to a situation where they are in the presence of peers that would possibly provide support to speak out about sensitive issues.

5.4 Data Management

The data and information gained during my fieldwork in Durban was safely and securely stored. Written material on paper was kept safe, and digital written and oral material was kept safely on a computer protected by a password. During the writing up of this thesis all data was safely secured, and all data that can possibly identify the participants in the study will be safely stored for 5 years at the University of Oslo.

5.5 Ethical considerations

Young homeless mothers in Durban, South Africa can be incorporated into the group homeless youth. They are without permanent housing, they live in poverty, and they are young, here defined with the age group 16-25. Homeless youth are both medically and socially a vulnerable group, and thus important ethical issues needs to be considered when involving them in research (Ensign, 2003). Here I will briefly discuss some of the most important ethical issues when homeless youth are participating in research.

5.5.1 Informed consent

Informed consent entails that participants should voluntarily take part in a research project and that they fully understand the consequences it has for them (Green and Thorogood, 2004). The legal age for being able to give informed consent is a debated issue. How old do you have to be to understand what it means being involved in a research project? Much research has been done to try to come up with the answer to this question, but a universal agreement is hard to come by. One suggestion is 14; at this age it has been shown that most adolescents are capable of giving informed consent to participate in a research project (Ensign, 2003).

When asking for informed consent from young homeless mothers many issues come up. Are they capable of providing this, are they literate, and if not do they have legal caregivers that could sign for them?

In this study it was unclear if the mothers were literate before the fieldwork began, so it was assumed that they were not. To get informed consent the informed consent form was read and

explained to the mothers, with a witness that they trusted present. Any questions they had were answered. If the mother agreed to participate the witness was asked to sign on behalf of the mother. The mothers were also asked if they were ok with this form of providing agreement to participate in the study. With this method the mothers' identity was protected.

5.5.2 Ethical aspects of giving incentives

Paying participants back for inconvenience or travel expenses is ethically acceptable, but payment beyond this or other reimbursements is often considered incentives that could be confused with trying to influencing subjects to participate (Ensign, 2003).

When it comes to youth, what is acceptable as incentives is, as informed consent, a debated issue. Often local context informs this issue. Money is not often used, as it is seen as coercive and a means to buy drugs (Ensign, 2003).

Some of the staff at Umthombo was consulted regarding the issue of giving the participants something for the time they spent doing interviews and focus groups. It was suggested giving them a meal before we conducted an interview or a focus group, something the Umthombo staff-members agreed was an appropriate reimbursement.

5.5.3 Vulnerable populations and the role of the researcher

Vulnerable people often have less power to take actions and claim rights to improve their lives. As researchers this is important to keep in mind when involving them in research (Ensign, 2003). Firstly, they might fear that saying no to participate in research will have negative consequences for them. Second, they might feel pressured to participate due to the unbalanced relationship of power between them and us, the researchers. This relationship might also be influential throughout the research process if the participants feel they have to provide certain answers to please the researcher.

Before the initiation of data collection for this study, and throughout the research process, it was made very clear to the participants that being involved in this project is voluntary, and at any time they could choose to withdraw without giving an explanation for why. It was also made perfectly clear that if they chose to not to participate or withdraw it would have no consequences for them. Further, it was a goal to create an atmosphere where the participants understood that the

information and experiences they shared were valuable to the researcher, and that this was a process of learning from each other (Ensign, 2003).

We did, as far as possible, seek to conduct the interviews at a place and in a setting where the informants felt safe and comfortable. We also took great effort in making the children of the mothers safe and comfortable. The children were allowed to be present during the interview if the mothers wished so. Three of the participants had their children with them during the interviews, in accordance with their own wishes. The children seemed comfortable during all interviews. One child was also present during one of the focus groups after being brought in because she was crying while a staff at Umthombo was looking after it. This caused no significant interruption. Whatever the mothers were most comfortable with when it came to their children was respected, however the child's safety and best interest was always a priority.

5.5.4 Confidentiality and Anonymity

Confidentiality and anonymity is one of the most difficult ethical issues in qualitative research, as it is very difficult to assure this totally (Ensign, 2003). This is because people usually talk about personal experiences in interviews, and thus can be identified if the details are very specific. Focus groups are also a problem due to the fact that it cannot be guaranteed that the participants keep what is discussed confidential (Ensign, 2003).

What was possible to maintain confidentiality and anonymity for the research participants was done in this study. The names of the participants were never written down, instead numbers were used to not reveal their real name. Also, as mentioned above, a witness was asked to sign the informed consent form, to avoid having the real name of the women on any official document. Firstly the women were informed about the study and asked if they wanted to participate. After getting oral consent to participate, it was explained that a witness would sign on behalf of them to obtain written consent. After they agreed to this, it was asked if it was ok that the research assistant, a staff-member at Umthombo and someone they knew well could sign on behalf of them, something all the participants agreed to. On all but one occasion the research assistant signed the consent-form on behalf of the participants. For participant number 4 another staff-member at Umthombo signed the consent form, also someone who works closely with young homeless women and mothers. All documents produced during the research process were safely and securely stored.

5.5.5 The influence on the researcher/ how to end the relationship

Research involving vulnerable populations often entails hearing life stories of people living in difficult circumstances. During interviews and focus groups the researcher engage in close and personal meetings with the participants, and the researcher needs to be aware of possible consequences this will have for him- or herself (Ensign, 2003).

It is recommended that the researcher create contact with people that have experience with and knowledge of the specific vulnerable population, and that they can be contacted by the researcher when the need is there for clarifications or just to talk (Ensign, 2003). In this study the researcher spent a lot of time with the people from Umthombo who worked with people living on the streets, and accompanied them in their daily tasks around Durban. They were open to any questions the researcher had during data collection and after.

Another ethical issue when working with vulnerable populations is that the participants may develop expectations of the researcher as there is an unequal power-related relationship between them, as discussed above. It might be very difficult for the researcher to just end the relationship that has been developed after months of work. It is recommended that the process of leaving the field should be thought about before it starts, so one is prepared. It is also recommended that the researcher familiarizes him-or herself with places and services that could be referred to when participants need further advice or help (Feldman et al, 2003). As the participants in this study were all familiar with Umthombo, an organization they often came to for help when in need of heath care, no participant had questions regarding other places or services. As for the end of the relationship between the participants and the researcher, efforts will be made to keep some contact through the research assistant via email. A copy of the finished thesis and a shortened version of it intended to be of value to the participants will also be sent to the research assistant and the participants.

5.6 Reflexivity

The idea for this study originally came out of a meeting I had with a member of Umthombo in Durban in 2007. We had a long talk about homeless youth in Durban, and one particular group of young homeless mothers. She explained that their access to health care was very low and that it was one of the situations they were trying to improve in their work with homeless youth.

When I met with the woman from Umthombo it was my first visit to South Africa. When I left for Durban to conduct my fieldwork it became my third stay in the country. I thus knew a little bit about the country, its diversities and its inequalities, however, my assumptions about young homeless mothers were proven wrong. I assumed that young homeless mothers would be sitting on every corner in down town Durban with their children on their laps, begging for money. Instead I met a group of women that looked more or less like every other young women in down town Durban, and it was seldom I was able to meet their children. The young mothers rarely begged, rather they worked odd jobs to collect a little bit of money to get some food for the day.

As a white female from Europe it was not always easy to walk around down town and collect data through interviews and focus groups. I sometimes drew more attention to myself than I liked, which also disturbed the data collection on occasion. In addition, I was affected by all the advice I received about how dangerous down town Durban was, which sometimes made me nervous to head down town in the mornings to start a new day of fieldwork. Fortunately, I had a good research assistant and interpreter who guided me around and chased away any potential dangerous situations. We became good friends during the experience of fieldwork, and we still keep in touch.

That the setting for the fieldwork sometimes made me nervous could have affected the atmosphere during some of the interviews, especially at the beginning of the fieldwork. However, I believe that after a few tries, and with the support from my assistant, we were able to create a comfortable environment for both the participants, the assistant and for myself. That this was my first fieldwork also affected the process, nonetheless I have learned a lot from the experience and made some acquaintances I will always value.

6. Findings and discussion

The findings of this study are organized in the following categories; 1; The life of the homeless mothers. 2; Perceptions of health. 3; Access to and utilization of health care. 4; Barriers to health care. 5; Quality of health care. The categories are organized into chapters that correlate with the categories. Except for the first chapter, which is meant as a presentation of the participants, each chapter will begin with a presentation of the findings, then discussion of the findings will follow with each chapter. We will conclude with a discussion where we draw together findings from all the chapters. All the participants have been given pseudonyms to protect their identity and preserve their anonymity.

6.1 The life of the homeless mothers

The participants in this study were all young women, of African origin, between the ages of 16 and 25, who had given birth, and who were homeless. All the participants were all familiar with the non-profit organization Umthombo. This is an organization for and by street children in South Africa, with their main office in Durban (Umthombo, 2008). The life of these participants will be described in this section. The section provides some background on the participants and is divided into some discussion around their age, their 'homeless' situation, health and illness, and children. These are important issues to discuss to get to know who the participants of this study are. They are all different, but also share similarities around their experiences with homelessness, motherhood and health. This first section is meant as a means to get a picture of who the participants in this study are.

6.1.2 Reasons for homelessness

There are multiple reasons why someone is homeless is South Africa. HIV and AIDS is one of the main factors, but also poverty, sexual or physical abuse and neglect are factors that lead to homelessness (Haldenby et al, 2007, Hudson et al, 2008, Olufemi, 1999). These reasons where highlighted by the staff at Umthombo during interviews. Some of these reasons where also recognized among the young homeless mothers when discussing different reasons for their

homelessness during the interviews.

Many of the cases from this study showed that homelessness for adolescents or children is a result of the death of one or both parents. The care for the adolescent or the child then falls on the single parent or other relatives. The single parent might not be able to take care of his or her children by his or her-self, and relatives often have their own children to take care of, so the result is often that the adolescent or child is forced to try to survive on his or her own. This is the story of several of participants in this study. Nozipho had a father who drank and could not take care of her and her baby. Nomusa had an aunt with several other children to take care of, so she felt she could not stay with them all the time. For some it was poverty that was the main reason they left home; their parents could not afford to take care of them so they had come to Durban to look for work and ended up on the streets. Jabulile told of her single mother as one of the reasons she could not stay at home anymore. She also mentioned discrimination as a result of her HIV status as another reason, as her neighbors had found out and told their children not to play with her. A third reason was that being at home reminded her of the deceased baby and that is was too hard to be around the memories.

"*I couldn't stay at home because I was always thinking of him, every time I stay at home I see his clothes, his blanket, then I think of him, I feel like he is next to me, when I look he isn't there. So I couldn't stay at home for long, sometimes I do go home, but...*"

Jabulile

The grief of her loss became one of the reasons why she could not bear to stay at home. As she mentions, she did go home sometimes, as did several of the other participants from time to time, a phenomenon that will be discussed below. This particular participant had several reasons for why she was living on the street most of the time and they all worked together as constant forces against her permanently returning to home. Nevertheless, as these reasons were keeping her from returning home, she also seemed to have a great desire to go home. Jabulile talked warmly about her stays at home on several occasions during her interview, about what she was doing when she was there and about her family.

"*...I wake up in the morning, 5 o'clock when they waking up, after they finish having a bath, I just wake up, make my bed, wash the dishes, put mr.man in the furnitures, shine everything, open the door, play some dvds, radio (laughs)...*"

Jabulile

Jabulile had a big smile on her face when she was talking about this, and one could see that it was something she associated with being happy. However, it would seem that the forces that kept her away from home were stronger than the ones that were making her stay. Most of the participants

in this study conveyed a great desire to be able to stay home and live there and on many occasions participants spoke like they were still living at home.

6.1.3 Age

The participants in this study were between the ages of 16 to 25. Most of the participants were around 20 years old. The age of the participants were never checked, firstly because few of them had proper ID documents, and second because the research assistant had more or less accurate knowledge of how old the participants were. Lastly, the ages that the participants gave were trusted to be true.

Although the participants were between 16 and 25 years old, they appeared to be much younger. On average the participants looked about four or five years younger than they were. For example, one participant claimed her age to be 19, however she looked closer to 15. She was quite thin and had the height of a normal 15 year old. She also had patches on her head with no hair to suggest that she was undernourished. This was also true for other homeless youth and children. Several young boys that the researcher came into contact with where said to be 17 and 18 years old, but if one where to guess their age based on their appearances one would probably say they were 13 or 14 years old.

What was most striking when it came to the participants' appearances were their height and weight, and other physical underdevelopment. Compared to youth their age in other segments of the society, they appeared shorter, thinner and behind in general physical development. It is common among children who spend most of their time on the streets to be physically underdeveloped due to lack of proper nourishment and other necessities for a healthy life (Barry et al, 2002, Verma, 1999).

6.1.4 Homeless; a fluctuating situation

Homelessness was a fluctuating situation for the majority of the participants in this study. This means that most of the participants had family, relatives or friends living in Durban or in townships around Durban, which they would go to and stay with on different occasions for different reasons. There was no apparent pattern of why they went 'home', however some mentioned issues like missing their mother, that they wanted to see their baby or that they needed money or food.

The participants in this study were all without a proper and permanent home, however in different manners. There were two different forms of living amongst the homelessness participants;

the ones who basically lived on the streets and the ones who stayed at some sort of shelter. In this section the participants who live on the streets will first be described, then the participants who stay in some sort of building will be dealt with. Based on the discussion of homelessness in conceptual framework, the mothers who lived on the streets will be referred to as absolute homeless, and the mothers who stayed lived on the streets but on occasions went 'home' will be referred to as first degree homeless because they move between the streets and a 'home'. Lastly, the mothers who stay in a form of shelter or abandoned building will be referred to as third degree homeless (UNCHS, 2000).

The participants who stayed on the streets, the absolute homeless, did not have a permanent roof over their heads, but stayed in more or less permanent spots in different parts of the city. It seemed that the choice of location was based on whether or not they would be able to seek cover from rain and wind near by, and also on whether or not they felt relatively safe in that location. Some of the participants stayed around a place called the 'drop-in center', a small center run by Umthombo at an area of Durban called the Victoria Embankment, which is a section of the city close to the harbor. This center was made up of 4 old trailers set up to form a sort of circle with a few tables in the middle. One trailer was used as an office, one was used for meetings or work-shops, and the remaining two were equipped with bathroom-facilities where the homeless youth could wash themselves and their clothes. The trailers were surrounded by a fence and had a tent over it for protection against rain and wind.

Young homeless children and youth were welcome inside the center during the day, but could not sleep there at night. However, a lot of the participants had made this area their home. They either slept around the center, close to the fence, or a little further away, anywhere they could find protection from wind and rain. As the center was open from the early hours of the day until around seven at night with staff from Umthombo and a guard, many of the participants spent most of their day here, and thus it can be assumed that they viewed it as some sort of base where they also felt they were safe at night. They center also had several old red mailboxes set up in the front who served the purpose of small lockers for the youth. They each had one where they could keep some of their belongings, and they were each provided with a lock to keep others from getting the contents. This could be another factor for why so many of the participants chose to sleep and stay around the drop in center, as they had a relatively safe place to keep some of their stuff, which in turn could create a sense of belonging.

The drop-in center was as mentioned located along the Victoria Embankment. This is a part of the large down town area of Durban. Some parts of the down town area in Durban is controlled by groups or gangs, and different segments belong to different gangs. This is something people who

live on the street have to take into consideration when moving around down town, and also when deciding where to stay for the night. The opportunity to come to the drop-in center was thus restricted for some as it was part of one area of Durban that was under the 'control' of a specific group, and hence not a safe area for people not belonging to this group to be in.

The participants who did not feel safe staying at the drop-in center had to find other places to sleep at night. One other example where a few of the participants where staying at the time of the study can only be described as a small garbage-dump. They had created a sort of base around a small electrical house or an el-box, in between two roads in the middle of down town. There were some buildings near by that they could seek shelter next to if it started raining, and there were some shops selling tires that usually gave them water. They thus seem to have the basic necessities near by, which seemed to be the reason for choice of location.

As explained above, some of the participants who lived on the streets had relatives living in the different townships surrounding Durban. Townships are areas where the black population was forced to live during the period of apartheid, and today it is still mainly populated by the black or colored segments of the population in South Africa. The participants with relatives in a township visited them and stayed with them at times, some once a month, some more often, some less. Some of the participants often called this place they visited on occasions their home, and referred to it with “at home”. The participants who lived on the streets, but who sometimes went home would classify as first degree homeless (UNCHS, 2006). Similar findings have been found in studies from USA. Ensign and Gittelsohn (1998) found that homeless youth tend to keep in contact with their families after they become homeless. The reasons behind the continued contact were explained to be social contact, support, and to get advice on issues regarding health (Ensign and Gittelsohn, 1998). Another study from the same area showed that young homeless females often keep in contact with their mothers or grandmothers for health advice (Ensign and Panke, 2002).

The other form of homelessness amongst the participants was to stay in various buildings. This was either a shelter or some sort of abandoned building. All the participants who stayed in some sort of building had previously been living on the streets for many years. They were still very much labeled as homeless on the same basis as the participants who still lived on the streets as far as the researcher could tell. Some of them still came to the drop in center to get something to eat, and hanged out there during the day. According to Cooper's categorization of homelessness, these mothers qualify as third degree homeless (UNCHS,2006). They stayed in shelters or buildings that were run down, without water and electricity, and they were far from adequate in terms of security.

One participant stayed in a shelter. The shelter was mixed between men, women and children. The building where the shelter was located was extremely run down. The shelter was

divided into different sections, one with small private rooms, one with bathrooms and a place to wash clothes, and one big dormitory with several bunk-beds. Mbhali was staying in a private room at the moment, which she was able to do because a local organization was paying for it for her. The organization had paid her rent so she would be able to stay there for six months. The room was very small, with one single bed, a small table with a radio on it and a cupboard with a few food items. Mbhali was a mother of one, with one deceased child. She was also pregnant. Her remaining child was staying with the parents of the child's father. She was not able to provide for the child herself as she had no job and was relatively ill. She did however receive help from the local organization with a roof over her head, and they also helped her with health care and medications for her illness. She had been staying at the shelter for a few months, before this she was living on the streets.

Two other participants stayed in an abandoned building on Point Road in the down town area. This area of town is considered to be a relatively 'bad neighborhood'; most of the buildings are run-down, there is often police patrolling in the streets, and many homeless youth call this road their home. The building the participants were staying in is a known building for homeless people to occupy. It is an abandoned building, however, there are some people who claim ownership over it, and the people who occupy the different rooms have to pay 'the owners' to be able to stay. No one except the people occupying the building are allowed inside, so the researcher was not able to view the conditions of the space, however, from the appearances of the building on the outside, what was told of the inside was assumed to be true. The building had no glass in the windows, no electricity and no running water. One participant explained how they were staying next to a toilet, which had been out of order for weeks, however people were still using it. Her main concern was to keep her children away from dirt, which was very difficult with the conditions she was living under.

The living conditions of the participants in this study could this be divided into two groups, those with no roof over their head, and the ones who did have a roof over their head. Further, as explained above, the participants could also be divided into absolute homeless, first degree homeless and third degree homeless (UNCHS, 2006).

6.1.5 Health and Illness

The participants in this study had a variety of current and prior illnesses, but there were a few that were more common than others. The most common illnesses among the participants were cold or flue. STIs were also very common among the young homeless mothers. Some of the participants also had TB and some were HIV positive. This information is mainly based on what the participants said during interviews, but also from the interviews with Umthombo staff. It is fair to

assume that most of the participants were HIV positive due to the high risk group they are a part of. South Africa has the highest number of people living with HIV in the world, and among the most vulnerable are young black women in urban areas of lower socio-economic status (UNAIDS, 2007, Connolly et al, 2004, South African Government, 2007). Several of the participants had not been tested for HIV however, and did not know their status. Some of the ones who did know their status spoke about this openly during interviews.

The majority of the participants looked relatively healthy. On the first encounter one could not see any apparent wounds or soars, their clothes seemed relatively clean, and one noticed some of the participant's nicely braided hair. However, after some time with observation, you could see signs of bad health with several of the participants. As explained before, some of the participants were quite thin and some were shorter than average for their age. Some also had patches of hair missing, a sign of vitamin deficiency (Verma, 1999). Also the skin of some of the participants was quite dry, and you could see old scars that showed signs of illness.

Many of the participants talked about their illnesses or diseases. Some of the women were quite open about their health-situation, and told of their HIV positive status and how they dealt with it. A few of the participants were very knowledgeable about HIV, at least to a certain degree. They knew of CD4 count and about medications and how important this was. One also told the researcher that when she is around people who have TB she asks them to cover their mouth when they cough, because she knows it is contagious.

"*Even when I am sitting with people, especially those who have TB, I know that TB is contagious, but I tell them that when they cough they must try to block their mouths, because I am thinking of my own health*."

Mbhali

6.1.6 Children

There are many young women who are homeless in down town Durban. Many of these are mothers per definition, that is, they have given birth. However, there are not many young mothers living with their children on the streets. It has been shown that it is common for homeless mothers to leave children with relatives in South Africa. Olufemi (2000) found that 60 percent of homeless mothers in Johannesburg left their children with their families.

Between the participants there were four different categories of motherhood; mothers living with their children, mothers who had their children living with relatives, pregnant women and

mothers with children who had passed away. However, some of the participants belonged to several of these categories, for example Mbhali who was pregnant, had one deceased child, and one child living with relatives.

All but one of the participants had given birth. The most common number of children was one or two. There was one participant who was pregnant, but had no children yet. She was included because it was thought that she would have the same concerns about health as the other participants in terms of having to care for someone in addition to herself. It was also thought that it would be valuable to include someone who was pregnant it terms of how the view on health possibly changes during this period.

Few of the participants who had already given birth were living with their children. Most of the children were living with relatives in various townships around Durban. This seemed strongly connected to the fluctuating state of homelessness of some of the participants as mentioned above; if the child was living with family or relatives, the desire to go home seemed strong. The mothers who had their children living in situations like this often said the children were better taken care of by their relatives and that the children were better off in a home. Nevertheless, the long for the children was always there, and for some of the mothers the greatest wish was to be able to stay at home and take care of their children.

"*I face many difficulties because I live with my aunt. Sometimes she has that thing that she is not my real mother, like I am a burden to her. Yeah she has that thing she likes to shout a lot. But I am glad that she is keeping my baby, I just want to keep her safe*."

Nomusa

Nomusa's aunt was currently taking care of her baby, and at times Nomusa was staying with her. She was complaining that her aunt used to shout at her a lot, but she also explained that her aunt takes good care of her baby, and that the reason she shouts was probably that she did not like the participant not being there for her baby.

Some of the participants had lost their children. They were either deceased or they had been adopted away. This was a difficult topic to talk about for the participants who had experienced it. Jabulile said that it was too difficult to stay at home because it reminded her of her child. Lindiwe had experienced that her child had been adopted away abroad without her permission. This had happened when she left her child with a local organization which takes care of children who's parents might not be able to take care of them for a while. She left her child with the intention of taking her back after some time. The child was sent abroad for adoption without the knowledge or permission of the mother, something that left her with great sorrow.

Three of the participants were living with their children. Two of these were in a relationship

with their children's father. The fathers were both doing odd jobs like guarding cars, which did not always bring in money. Nevertheless, it seemed like being two made it somewhat possible to take care of a child. The mother could then care for the baby and the father could bring in some money to provide for them. However, taking care of a child while being homeless seemed extremely difficult, and the few who had their children with them were working hard to keep their family together.

"*The thing is I don't get everything that I need. Because their father is not working...and he hustles, like now I haven't got nappies, I don't know what to do, but I think he'll make a plan.*"

Nompilo

This section was meant as a possibility to understand who the participants in this study are, and to provide some insight into their daily lives. Who these women are, and the context in which they live is what the rest of the findings are based on, and thus it was important for us to introduce the reader to our participants.

We will now look at the rest of the findings of this study, first what we found on perceptions of health., then access to and utilization of health care, followed by barriers to health care, and lastly quality of health care and the influence of health workers.

6.2 Health

One of the specific objectives of this study was to explore how young homeless mothers in Durban perceive health, and if being a young homeless mother influences the perception of health. We also wanted to explore the awareness of the most common illnesses and diseases amongst this population, and how this influences health seeking behavior. Lastly, the issue of health and motherhood was something we wanted to look into. In this section we will first talk about what it means to be healthy for young homeless mothers in Durban. Then we will explore the awareness of illness and disease, and last we will discuss if being a young homeless mother affects the perspective on health.

6.2.1 What does it mean to be healthy?

One of the findings of this study was the participants' perceptions and experiences with

health. Health was commonly associated with taking care of oneself, by being clean and eating healthy food. Almost all participants talked about one or all of these issues when discussing what being healthy meant to them.

First of all being healthy was strongly associated with being clean. Being clean was most strongly associated with taking a bath, which to seemed to be a part the daily routine of the majority of the participants. When the participants talked about what their normal day looked like several said the first thing they did every day was to take a bath.

"*I wake up, I clean where we were sleeping, and then we go to bath.*"

Thoko

"*In the morning I wake up and try to find food, then I go to the beach to bath.*"

Nomusa

Some of the participants also associated being healthy with being clean because they were girls.

"*...when you are a girl, you must always be clean. Clean and healthy, taking care of yourself...*"

Jabulile

Many of the participants were quite particular with what they wore everyday, how their hair looked, and several of them also had lip-gloss that they used and shared with each other. It was also important for them to have clean clothes, and also not to wear the same thing every day. The participants who hanged out together everyday often switched clothes in between themselves. To look nice and clean was important when you were a girl, and a girl who was nice and clean was also healthy.

The participants also expressed that to not be dirty or avoid dirt was to he healthy. One participant perceived the place she and her children where staying in as very dirty, and talked about how it is very difficult to keep her children healthy when they are living in such an environment.

"*The place that I am staying at, firstly its dirty, and I not always able to watch them, especially the older one, because where we are staying is dirty, and we are staying next to a toilet."*

Nobuntu

Staying away from dirt was also talked about in terms of avoiding diseases by some of the participants. Good health was considered to protecting oneself from diseases. One way to do this was to not have unprotected sex with a man. Discussion around sex and unprotected sex was not

something that was brought up further during this study.

When the participants talked about how they stayed healthy they also talked about the importance of good and healthy food.

"*The most important thing in taking care of myself is to know who I am no matter if I am sick. I am always worried about this sickness that I have, and I have to eat healthy food.*"

Mbhali

Mbhali was HIV positive and quite aware of her condition. She talked a great deal of how it was important for her to always take a bath and be clean. She was also particular about washing her hands before she ate. She was worried about getting any infections due to her condition, and one of the ways she was trying to avoid this was by eating healthy. Eating healthy was however something that seemed important to most of the participants as one expressed; "You must choose the food you eat, not just eat everything".

Similar findings like the ones mentioned here about perceptions on health by young homeless mothers were also found in Haldenby et al's (2007) study about health and homeless adolescents in Toronto, Canada. Some of the participants in their study associated being healthy with 'having access to resources', which meant having a place to shower or a place to live (Haldenby et al, 2007). Being able to eat every day was also something mentioned by some of the participants in relation to what it meant to be healthy (Haldenby et al, 2007).

Other studies that have looked at what homeless youth associate with health have found that it often depends on the context the homeless are in (Ali and Muynck, 2005). A study done in Pakistan among a group of street children found that health was viewed in the light of their everyday life, which consisted of working the whole day to make money to survive. Thus health was a state that allowed them to work and illness was something that prevented them from it (Ali and Muynck, 2005).

Flick and Röhnsch (2007) found that homeless adolescents understanding of health is often based on their social surroundings and the context they live in, similar to Ali and Muynck (2005). Subjective perceptions of health can be shaped by age, gender and cultural background. How someone views health affects how they perceive influences on health, and what they themselves can do to stay healthy (Flick and Röhnsch, 2007). Flick and Röhnsch (2007) found that health can be something that depends on the individual. If you become ill it is your own responsibility. Illness thus becomes something you want to avoid and health becomes a state as a result of preventing illness (Flick and Röhnsch, 2007). During one focus group in our study a similar view on health

emerged during discussion. The participants spoke of health as a state that was preserved because of certain practices. One of the participants said that health was to protect oneself from disease. Another said that it was to protect yourself from dirt and flies, and that when flies was on your food, you must not eat that food. It was thus a common view among some of the participants that health was your own responsibility; it was something that had to be protected by taking care of oneself and avoiding practices that could make you ill.

One issue in relation to young homeless mothers health that came up when talking to staff members at Umthombo was nutrients. Several of the staff members expressed that one of their major concerns was that the babies of the homeless mothers did not get all the nutrients that they were supposed to because the mothers lacked knowledge of and access to them.

"*..their kids are not like fed, like with proper nutrients, they don't get like the proper nutrients....*"

"*...they don't like know how to feed their babies. And some of them they don't know whether it is good, or maybe some of them are sick, they don't know if it is good to give them the breast-milk or what.*"

There was a concern for the wellbeing of the children of young homeless mothers amongst the staff at Umthombo. They know that many of the people on the streets are sick, some are HIV positive, and they lack knowledge of what a child needs in the early months and years of its life. The staff at Umthombo also expressed that the mothers are not properly fed either, and not having a proper diet is not good for a pregnant woman. However, with this concern came an understanding for why the young homeless mothers lack proper nutrients; that they were alone, with lack of support from relatives.

The staff at Umthombo expressed a concern for the lack of nutrients for the mothers and their children as a consequence for living on the street. They expressed that they did not get enough of the nutrients they needed through food because they could not get a hold of it or because they did not know about their importance. However, for several of the young homeless mothers in this study it was viewed as important to eat good food, like fruits and vegetables, to be healthy. This indicated that even though they might not be able to eat good food and get all the nutritions they need every day, at least it was something they saw as important in order to stay healthy. As we will discuss below, eating good food in relation to staying healthy was viewed as even more important by some of the participants when talking about taking care of their children. The staff members at Umthombo are probably correct in their opinion that the mothers and their children lack nutrients, but their view that the young mothers do not know the importance of healthy food and nutrition

does not hold true for most of the participants.

6.2.2 Awareness of disease and illness

The participants who talked about their illness during interviews seemed to have fairly good knowledge of their illness and their condition. There were a few participants who openly, without being asked, talked about their HIV status and how they were dealing with it medically. Jabulile talked about her CD4 count, about how she always made sure she did her CD4 count and how she was able to make health care professionals at different clinics perform the procedure.

"*When they ask me if I have done CD4 count I tell them no because if I tell them I did do a CD4 count they wont do me, because they tell me I must go back to the same clinic where I did the CD4 count , they wont stop, so at first I tell them 'no, I didn't have a CD4 count yet', then they start again to take blood, and then they tell me when to come back to do my CD4 count again.*"

Jabulile

Some of the participants possessed this kind of agency when it came to how to deal with the health care professionals and the health care facilities. This form of agency will be discussed further under 'access to health care'. The participants who had this type of agency knew what they needed to do to get the help that they needed, and they knew what was required of they to keep getting this help;

"*In my life I want to make sure that the doctor sees that I am taking my treatment, because we were told to always come to the clinic so they can see how the ARVs are working in the body. And you have to make sure that you make sure that you go on the date you are given, not before or after, that is why I always make sure I go to the clinic.*"

Mbhali

Mbhali was involved in a study on HIV, and was receiving treatment for her condition through her involvement. Through this program she had learned quite a lot about HIV and AIDS, and was well aware of the treatment and the most likely outcome. That she would most likely die from an AIDS related illness was something that stressed her quite a lot;

"*...I have that thing that I am not ok, I can die any time. Sometimes I have that stress*."

Mbhali

The participants who spoke of their illness were aware of their condition, and it seemed to

be a significant part of their daily life in terms of how they viewed their own health. It was important to them to see a health professional regularly, they listened to the doctors and that they made sure they ate well and took care of themselves hygienically.

Most of the participants in this study were more or less aware of different illnesses. When asked if they had been ill lately, several of the participants answered with naming the illness they had experienced. Many of the participants also expressed that when they had an illness they went to a clinic. Other studies have also shown that homeless youth are in general aware of common illnesses and conditions and the symptoms for these (Ensign and Gittelsohn, 1998, Ensign and Panke, 2002, Rew et al, 2002). The possible implications for this awareness will be discussed under 'utilization of health care'.

6.2.3 Health and Motherhood

The focus of this study was young homeless mothers and access to health care. The main reason for this was that we wanted to gain insight into how it is being a young mother and at the same time being homeless, and if this influences how they think about health, and how they seek and use health care. Although not all mothers had their babies with them we wanted to know if having children would make a young homeless woman think differently about health. We also wanted to know if there were good health care services for young homeless mothers, and if not, how they could be improved. To do this we needed to listen to the young homeless mothers experiences and perspectives.

This issue of feeling differently about health after having children was something the participants where split on; about half said they felt differently about health after having a child/children. The other half expressed no significant change in their view on health or how they acted in relation to health after having a child/children. This division did not correlate with whether or not the participants had their children living with them or not.

Most of the participants who had their children living with them said that they did not feel different about their own health after having children. This was something that was not expected. One would probably assume that living with children while being homeless would change how one views health or that being healthy and keeping the children healthy would become more important. However, we only asked if the participants felt differently about their health after becoming a mother, so a negative answer to this question does not mean that health had become less important, only that it had not changed. The mothers might have thought health was something that had been

important all along, and that this had not changed after they became mothers. It would have been interesting to explore this topic further.

Some of the participants who did express that they felt differently about their own health after becoming a mother mostly did so with talking about how the experience of having a child had changed them.

"*I have changed now, because I was able to go home and raise my own child. And I still want to go and stay with her and raise her.*

- Are you treating yourself differently after you became a mother?

I am taking care of myself more after having a baby. And with her also, when she is sick, I have to know what she has, and when she is hungry, I have to give her food."

Nomusa

Nomusa's child was living with her aunt, however she did go home on occasions to be with her baby. She became pregnant while living on the streets, and went home to her aunt for a while to raise the baby. Before she had her baby she cared very little about her health, she did not care whether she was sick or not. She explained that before she just used to hold on until she got better because she was scared of going to the clinic. One of the reasons she was scared was that she thought she was going to be judged and treated differently because of the way she was living.

Nomusa was still living more or less the same life as before, but something had changed after she had the baby. As mentioned, she went home more to be with her baby, and she seemed very concerned about the wellbeing of her child. She was grateful that her aunt was looking after her baby, as she wanted to do this herself but felt she was not able to. She said she sometimes felt like her aunt treated her as a burden, and thus she could not stay there all the time. However, she was very attached to her child, and expressed that all she wanted was to keep her safe.

One participant who had a deceased baby also expressed feeling differently about health. The experience of having a baby had changed her in terms of how she saw herself;

"*Now I am taking care of myself much more after having a baby. Now I am older. Before I had a baby I wasn't thinking like an adult, I was thinking like a child.*"

Thandiwe

She was an adult now, and that brought responsibility, if not for the baby then for herself. Adults take care of themselves, and so she had to take care of herself.

There were two participants who were pregnant at the time of the interviews. Both of them expressed feeling different about their own health now due to this fact.

"*...because I have a baby in the stomach, I always make sure that I eat right.*"

Mbhali

Mbhali was HIV positive, as explained above, and at the time of the interview she was living in a shelter in down town Durban. She was part of a program run by a local NGO, and they were paying for her accommodation while she was part of this program for six months. Before this she had been living on the streets. She had one deceased child, one child living with relatives, and now she was pregnant.

She expressed that she felt different about her health because she 'had a baby in her stomach', however she also said that she treated herself the same. The way she expressed how she felt different was to say that now she made sure she ate right. There seems to be a strong correlation among several participants between good health and good food as mentioned earlier. This correlation became even stronger when talking about motherhood and health.

Mbhali expressed that she treated herself the same, but she also said she felt different about her own health after becoming a mother and now being pregnant. An explanation for this could be that she knew how to take care of herself, but she was not sure about the baby. In other words, she still knew how to take care of herself, that was still the same, but how to take care of the baby she was not too sure about. However, she knew that it was important to eat healthy for the baby in her stomach. The other pregnant participant, Zanele, also expressed that she wanted to eat healthy because she was pregnant. As a token of appreciation for their time the researcher always bought some food for the participants after each interview and focus group. After the last focus group the Zanele asked the researcher to get her some fruits because she was pregnant now and needed to eat fruits because it was healthy.

When conducting focus group the issue of feeling differently about their health after having children was brought up again. However, here we asked if health was more important to the participants after having children. All the participants except one concluded with that it was very important. One participant expressed that she realized how important it was every time she went home and saw her baby. The other participants explained that now they were in a different situation and they had seen things they did not know of before they became mothers.

Some of the staff at Umthombo talked about how the state gives you benefits or grants when you have a baby. With this came the implication that maybe homeless mothers have children to get this type of grant. However, none of the young homeless mothers who were part of the study mentioned this during any interviews or focus groups. There was one incidence where a staff member with Umthombo was helping a young homeless mother with a birth certificate so that she

could apply for this type of grant, but it was never mentioned that getting this grant was the purpose of having the child. A grant is of course helpful when raising a child without a proper home or a job, but the need for the grant came after the baby, not the other way around.

For these mothers a child seemed to be a good thing, like it is for most mothers. Having a child was not a means to an end, but an end in itself. They all seemed to have great love for their own and the other participants' children. During one focus group Nobuntu had her baby with her, and all the other participants wanted to hold him and care for him. Children was a positive element in this environment, it represented joy, something to care for and possibly something that brought hope to their lives.

In the small amount of research performed on young homeless mothers the possible effect homelessness has on perspectives on health has not been explored as far as we know. There are some studies on homeless adolescent mothers that have looked at the experience of being a homeless mother. These studies have shown that young homeless mothers tend to develop feelings of responsibility because they are pregnant or have children. This responsibility leads to changes in lifestyle like decreased alcohol and substance abuse (Meadows-Oliver, 2006). In our study changes in lifestyle evolved more around the issue of eating healthy and taking better care of oneself, and not about reducing alcohol and substance intake. This could be because they did not think of it as hazardous to their health, or that they did not associate using substances with health in general because they lack knowledge of substances' long-term effects for their health. Nevertheless, there is a similarity in our findings with other studies in terms of wanting to take better care of oneself after having children.

It has also been shown that the meaning of health amongst homeless adolescents is to be able to do what they wanted every day and to be in a good state which allowed them to live their lives to their best abilities as homeless. When health was perceived as being the foundation of being able to function, health was also associated with eating healthy and being clean (Flick and Röhnsch, 2007). This was also the case for several of the participants in our study, who talked about eating healthy and being clean when discussing what health was. When this is seen in connection to that these participants are mothers, it could be argued that they needed to be healthy to be able to take care of their children, or to be able to take care of their children in the future. Whether they were living with their children or not did not seem to be an issue, it was rather that they had something else to think of in addition to themselves, and that was what made it important to be healthy.

In this section we have shown how the participants in this study perceive health, their awareness of health, and how perceptions of health can alter after having children. In general health

is perceived as something that is the responsibility of the individual. Health was to eat healthy and to be clean, and to avoid illness, which were all actions of individual responsibility. Further, most of the participants were aware of their own diseases and illnesses. Some spoke openly about serious conditions and how they dealt with it, and how they used health care services to take care of themselves. Finally, having children did have an affect for some of the young homeless mothers on how they perceived health. This was exemplified with taking better care of themselves in order to be able to take care of the baby.

6.3 Access to and utilization of health care

The main objective of this study was to identify access to health care for young homeless mothers in Durban, South Africa. This is a broad objective that has several angles. First of all we have to know how the participants in this study attain health care, how this process works and what it entails. We have to gain knowledge on whether it is a good or a bad process, if the mothers are getting health care, and on possible improvements or changes in order to make it better. To acquire knowledge on how to improve access to health care for young homeless mothers we also have to know something about what makes them seek health care, and what makes them not seek health care, in other words, the barriers to accessing health care for this population. It is important to keep the focus on the barriers as identified by the young homeless mothers themselves as it is vital to obtain their perspective to improve access to health care for this population (Riley et al, 2007, Ensign and Panke, 2001, Simbayi et al, 2007, Ensign, 2003, Loewenson, 2007).

This study is a concept-based study. The main concepts in this study are access, utilization, barriers, both supply and demand, and quality. The findings on access to care are organized according to these concepts. First I will discuss the findings on the two concepts of access and utilization. Then the findings on supply and demand barriers follow, and lastly we will discuss the findings on quality.

6. 3.1 Access

There are several health care facilities in down town Durban, however when we asked the participants about their use of health care services they talked about one specific facility with only a few exceptions. In all the interviews and focus groups most of the discussion referred to this facility, so it became the only health care facility the researcher observed. The information that follows referrers to this facility.

At this particular health care facility all patients have to get passed guards to physically access the hospital. They ask you who you are, if you have identification, and what you are there to do. This could possibly have influenced the answers given by the participants when asked about access issues in this study since some of the smaller clinics do not have the same security measures.

When we talked about access in terms of entering a health care facility several avenues for access where identified through interviews, focus groups and observations. The most important avenue to gain access to health care for young homeless mothers is having an ID, a birth certificate or a proof of residence. If you do not have one or more of these documents another option is to be accompanied by a staff member at Umthombo or a social worker. Lastly, some of the participants also possessed a form of agency that allowed them access to health care facilities.

An ID is an identification document that identifies a person as a South African citizen or a permanent resident. The ID was initially issued so that the government could ensure that all South Africans would have access to public services. It is normally given to all South Africans at the age of 16 (Human Science Research Council, 2004).

Having an ID was the single most mentioned method of gaining access to health care by young homeless mothers in this study. It was perceived as something you had to have to be able to acquire health care by yourself. If you did not have an ID you would not get access to a health care facility as the security or the health care personnel always asked for it. If you did not have it they would tell you to go back and get it, or come back with a social worker.

"*Its because you cant just go alone without talking to the social worker. If you go alone they ask you for an ID, proof of residence, and a certificate (birth). If you don't have them, they tell you to go back, they are not able to help you, until you get a social worker that will help you.*"

Nobuntu

There are however other ways to gain access to health care if you do not have an ID, birth certificate or proof of residence. Two alternative options came out of this study. The first was to be accompanied by a staff member from Umthombo or a social worker. Umthombo has been working

with homeless children and youth for a long time and is a known organization with many of the health care facilities in down town Durban. The people in the organization who help young homeless getting access to health care have over time built relationships with some health workers at some of these facilities. When they bring in a street-child with no ID or birth certificate there are normally few questions asked.

"*....if they are sick or pregnant I take them to (...) to the antenatal clinic. There is a lady there who I have to talk to cause most of the girls don't have IDs or proof of address, and yeah, she understands, she doesn't ask me for stuff because we have been working with her for two years now, yeah, since 2006.*"

Umthombo staff

During one of the focus groups we asked the participants if they thought Umthombo was important in relation to helping them get help at health care services. There was a general consensus that Umthombo was indeed important, because the staff at Umthombo helped the ones who were without an ID to get access to health care.

"*its the one who helped me when I went to the clinic because I didn't have an ID. They used to ask me a lot of questions like where do you stay, are you going to raise the baby there... when you go alone you don't get help, but when you go with Umthombo you do get help. I got help and started clinic (antenatal care).*"

Nobuntu

Sometimes a file was created at a health care facility because one was connected with Umthombo. This manner of obtaining access to health care was presented as an unofficial practice by the staff at Umthombo. It was performed on an individual basis, and it was only talked about in connection with one major health care facility in down town Durban. The few participants who had a file at a health care facility, and did not have an ID or a birth certificate, were young mothers who had been living on the street for a longer period and thus had obtained a great deal of street-knowledge. Lindiwe explained that she had a file at a health care facility; "Umthombo is important because now I can go to the clinic alone because I am under Umthombo, they just punch the computer." She did not have an ID, and had been living on the streets for several years. Lindiwe appeared like a very confident young woman who knew her way around Durban and what it took to survive on the streets.

The other alternative way to gain access to health care without an ID or a similar document was to have a certain level of agency that would allow you to access health care based on prior

visits to a health care facility and from acquaintances from these visits. If a mothers had been going to the clinic over a long period, and gotten to know some specific health workers, they received health care based on this connection. This form of agency was also gained through experience and having lived on the streets for a longer period. They knew where to go when they needed help, and they knew what to say to the guards at the clinic and to the health care workers. This agency allowed them to access health care by themselves without having an ID or similar documentation.

The two alternative avenues for access was thus mostly used by young mothers who had been living as homeless for a longer period and either had the knowledge or agency to access a health care facility on their own. The ones who lacked these attributes either had to use a ID or other forms of documents or be accompanied by someone from Umthombo or a social worker. Nevertheless, the most secure way of assuring access to health care for these young homeless mothers was to have an ID.

If the participants were able to physically access a health care service, it did not mean that they were actually able to access health care. Several of the participants had experienced long waiting hours to be able to see a health care professional, something they assumed happened because of their status as young homeless mothers. Another obstacle some of the participants experienced was that they got sent around when they south health care. After actually accessing the facility they did not get to see a health care professional because they were being sent from one place to another, which usually lead to them giving up and leaving. who had experienced this referred to it as being made to do 'up and down';

"*they make you do up and down, they told me to go there and there, when there they told me to go other side. They confuse me, I left that clinic and went to another clinic.*"

Jabulile

That they were going to have to wait for several hours was something they anticipated as some of the participants made a point of waking up very early if they knew they were going to the clinic. Nomsa who stayed around the drop-in center did not seem to have a problem going to the clinic, as long as she woke up in time;

"*...I just tell the security guards (at the center) to wake me up at 4. Sometimes I sleep behind the security office so that they can wake me up in the morning when I go to the clinic.*"

Nomsa

Based on the interviews with the staff at Umthombo the need to have an ID to be able to access health care services was confirmed. Their perspective was that most of the young homeless mothers have access to health care. However, this access comes with reservations. Either they do have to have an ID, birth certificate or proof of residence, or they have to be accompanied by a staff from Umthombo or a social worker. Some of them also expressed that now that with the Umthombo mobile health clinic, young homeless mothers did have access to health care. But this mobile health clinic can only offer a certain level of health care, so full access without ID or similar documents is still not achieved.

The Umthombo mobile health clinic offers a unique option of accessing health care for homeless youth, including young homeless mothers. The mobile health clinic is a large van driving around Durban. It has most of the basic equipment that is needed for basic health care. Most of the staff are volunteers from abroad who work for Umthombo for a few months.

The mobile health clinic was created after the staff at Umthombo got tired of seeing street children getting rejected at various health care facilities. They decided to create a form of health care service that would never reject the children and that would be able to meet the children in their environment; on the streets. The volunteers who drive around with the mobile health clinic normally deal with soars, cuts and infected fingers and toes. If there is a more serious injury or illness they take the child or youth to the nearest health care facility, and try to make sure the person gets the help he or she needs.

In terms of access the mobile health clinic offers a relatively easy way to obtain basic health care. It comes to the patients by driving around Durban and finding patients where they live or hang out and it does not require any form of documents of anyone to provide help. With what was said about access above, this would qualify as good access. However, access to health care through the mobile health clinic is not optimal. The patients cannot know where the clinic is at any given moment when they need help, and the clinic does not operate every day. It is dependent on having a driver and that there are volunteers available to work. The patients might have to wait several hours, or until the next day before they receive help due to these operational difficulties. Many of the participants in this study did however have mobile phones, and could call or text the driver of the clinic or another member of Umthombo when they needed help. They would then know where the clinic was and how long they had to wait to receive help, which usually happened the same day if it was urgent.

In this study we found that young homeless mothers do have access to health care. They have several avenues to access health care through; with an ID or similar documentation, by being

accompanied by a member of Umthombo or a social worker, by having a certain level of agency, or via the Umthombo mobile health clinic. Nevertheless, they do not have optimal access. Only half of the participants actually had an ID, which is needed to access health care as an individual. Some of the participants did find other ways of accessing health care by themselves, however, in most cases they had to rely on someone else to be able to get health care.

The implications behind these findings is that the health care system in South Africa has somewhat adapted to the situations of vulnerable population in the society as it allows access to health care to people who fall outside the system. However, this adaptation is unofficial, as there are no official guidelines or practices as to how to accommodate people who for example do not have an ID. Although the South African government has initiated several policies that work along the lines of vertical equity, they still have a long way to go before this principle is achieved (McIntyre and Gilson, 2002).

Ensign and Panke (2002) did a study where they identified several issues that made it difficult for young homeless youth to access health care. They found that one of the most important barriers was lack of health insurance. They were either denied help or they had to wait longer than usual when they did not have health insurance (Ensign and Panke, 2002). This is similar to not having an ID for the participants in our study. Without an ID they would most likely be turned away when they sought help at a health care service.

That some of the participants in this study possessed a form of agency that allowed them to access health care is something that has been recognized in other studies of homeless youth as well (Ensign and Gittelsohn, 1998). In their study on homeless youth in Baltimore they found that the participants were surviving under difficult circumstances through negotiating their way in their lives based on their strengths and experience. In terms of health seeking behavior they sought health care with different types of health care facilities, like the emergency rooms, different hospital clinics, mall-clinics and health department-clinics. The different types of clinics where used according to what type of health related issue they needed help with. They knew where to go and where they would receive the most appropriate help based on their experience of being perceived as homeless and their experience with the various health care facilities (Ensign and Gittelsohn, 1998).

6.3.2 UTILIZATION

One of the specific objectives of this study was to assess utilization of health care for young homeless mothers in Durban, South Africa. We wanted to know if the participants were able to use health care services based on the claim that they had low or no access to health care.

Utilization of health care is the actual use of health care services. This is here defined as if the participant actually gets to talk to a doctor or another health care professional, and if they actually receive care after accessing the service. We differ between access and utilization because to have access to a health care facility does not mean that one is able to take advantage of the services that they offer or that they are given to everyone who seeks them on an equal basis (Gulliford et al 2002, Oliver and Mossialos, 2004).

To explore the issue of utilization we asked the participants what usually happens when they seek health care and if they think they receive good health care when they do. The main issue was to explore if they actually were able to take use of the services they accessed. The results were that sometimes they did, and sometimes they did not. When talking about utilization of health care services the participants often mentioned bad treatment and not getting what they came there for.

During one focus group we asked the participants if they got help at health care clinics. The answer did not vary much and centered around that yes, they got help, however, usually accompanied by rude remarks, shouting and confusing advice. Jabulile said this when she talked about going to the clinic for help;

"when I go to the clinic, I get help, but they shout at me and help me. They just shout at me that time and then they help me".

Jabulile

She expresses that yes, she is getting help, however with additional shouting from the health care workers, which she does not like. Zanele also expressed a similar experience when she wanted to start antenatal care because she was pregnant;

"with me, I wanted then to help me with starting a clinic (antenatal care), not to tell me that I must go back home, and they mustn't tell me that I must go an stay at the shelter if I want help".

Zanele

The health workers had told her to go stay at a shelter if they were to help her. She went to the clinic to get help because she was pregnant, not to get a lecture on where to live. She did not

want a lecture, she just wanted help with the pregnancy.

Despite bad treatment and lack of willingness to seek health care because of it, the participants in this study all stated that they used health care services, and all but one expressed that they would go to a clinic if they felt they had to. The majority of the young homeless mothers were also very quick to answer on what they would do it their children were sick; they would take them to the clinic. The three young mothers who were living with their children all stated that if their children were sick they would take them to the clinic, and there was no talk about trying to take care of the children's' illnesses by themselves.

However, some of the participants expressed that, when talking about themselves, they would try to take care of a possible illness or pain before going to a clinic. This could be anything from not doing nothing about feeling ill, going to the pharmacy and buying tablets, or trying to get better through eating healthy or taking a bath. Mbhali, who was HIV positive, explained that what she usually did when she had a headache was to take care of herself;

"*...when I have a headache I drink tea or a cool drink and take a cold shower. And I try to rub myself using cold water so I don't feel pain in my body. The most pain that I am feeling is cramps on my legs, I have cramps on my legs. Sometimes I have cramps and I am unable to stand up or do anything. And maybe I will feel better after an hour.*"

Mbhali

Mbhali was however were explicit about that she did see a doctor regularly and that this was something that was very important to her. That she sometimes tried to heal less serious conditions by herself could imply that she used traditional health care when she saw that it was necessary, like when she needed to do her CD4 count. This was also the case with the other participants who expressed that they tried to take care of minor illnesses without going to a clinic. They sometimes tried to just let the pain pass or buy tablets at a pharmacy, however if it did not work they all said they would go to a clinic. This could imply that even though the participants had experienced poor treatment from at health care clinics, they would still go when they realized that they could not heal the illness or pain by themselves. It points back to the finding that most of the participants were quite aware of their illnesses and diseases, and that they sought help when they needed to.

A similar finding is discussed in Haldenby et al's study (2007) where homeless youth said they would use traditional forms of health care if they felt it was necessary, despite former experiences of bad treatment (Haldenby et al, 2007).

Ensign and Panke (2002) found that there was a tendency to use self-care to heal illnesses

before they sought help at a clinic among homeless youth in Seattle, USA. Their participants expressed that using a clinic was a last option, after attempts to take care of themselves did not work (Ensign and Panke, 2002). In our study seeking help at a health care facility was not mentioned as a last option. All the participants expressed that they would go to a clinic, however, some of them also stated that they sometimes would try to take care of minor pain themselves, however when it was serious diseases or illnesses, more serious than the flue, they would go strait to the clinic.

This difference in health seeking behavior in Seattle and Durban could have something to do with what the participants in the two studies perceive as barriers. In Seattle the participants viewed lack of insurance, confusion over consent, transportation problems, and lack of respect and judgment from providers as barriers to health care. In Durban the participants mentioned similar barriers like lack of ID or similar documents and lack of willingness due to poor treatment as barriers. Transportation problems was however not an issue that was brought up in our study, something that could make it more difficult to get to a health care clinic for homeless youth in Seattle than in Durban. The fact that problems with transportation are an obstacle for homeless youth in Seattle might influence their choice to use self-care as a first option, and traditional clinics as a last option only. For young homeless mothers in Durban it is possibly easier to seek health care based on their notions of few barriers to health care compared to homeless youth in Seattle.

The participants in this study express that they do get help once they have accessed a health care service. However, the utilization of health care is often accompanied by harsh treatment by health care personnel tend to shout at them and tell them things the participants do not want to hear when they are seeking health care. Nevertheless, the participants still seek health care in spite of the poor treatment when they realized that they need the help. At the same time the participants pointed out that they did not wish to be treated badly, they wanted the help without the lecture, which is something that has been found to be true for homeless youth in other studies as well (Ensign and Gittelsohn, 1998). Ensign and Gittelsohn (1998) also found that homeless youth see health care services as a last option (Ensign and Gittelsohn, 1998, Ensign and Panke, 2002), however, here it is one of the first options, especially for the participants who live with their children. Their awareness of illness, and their attentiveness to their children illnesses influences the use of health care services for the participants in this study.

6.3.3 Barriers to access and utilization

In this section we will present the findings on what made it difficult for the participants in this study to seek health care. One of our specific objectives was to identify barriers to health care defined by young homeless mothers themselves, and we were able to discover them by asking the participants what made it difficult for them to seek health care. As discussed in the conceptual framework we differentiate between supply and demand barriers. Based on the interviews and focus groups with the participants we found two supply barriers and one demand barrier to health care. The most important supply barriers were not having an ID or a similar form of document and low quality care in the form of poor treatment by health care personnel. The most important demand barrier was lack of willingness to use existing health care.

Here the supply barriers to health care for young homeless mothers will first be presented, then we will look at the demand barriers. Some of the discussion on the findings of both supply and demand barriers will however revolve itself around the issue of treatment. When talking about supply barriers we will mostly discuss access issues, then turning to utilization issues when discussing demand barriers in relation to supply barriers.

6.3.3.1 Supply barriers

Not having an ID was the single most mentioned barrier to accessing health care by the participants in this study, as mentioned above in the section on access. They claimed to be turned away when seeking health care without an ID or a similar document like a birth certificate or a proof of residence. During a focus group when discussing if it was important to have an ID to get help at a clinic or a hospital most of the participants agreed that without an ID you would most likely be turned away.

"*..before I had an ID when I went to the doctor they told me to go back...*"

Nomusa

"*it is important because if you don't have one you don't get help. They need it, so it is important to have one*."

Nobuntu

Several of the staff with Umthombo also stated that not having an ID was the greatest barrier to accessing health care for young homeless mothers. It was common knowledge with both homeless people and people working with them that if you went to a clinic without an ID you would most likely be denied access to health care.

"*...what happens is this, they go to hospital, not all nurses or all kids they get neglected or rejected from hospital, but what usually happens is when a child do not have an address or proof of residential address, they don't have an ID, they don't get accepted at the hospital because they are street children, and they don't have those documents, so they end up staying at the hospital the whole day without anyone coming to them or helping them or without a doctor or without anyone communicating with them. So they end up going and then they get sick on the streets until someone comes to us and says that someone is sick...*"

Umthombo staff

Several studies talk about access to health care for homeless people. Most of these have been conducted in North America. One of the main issues discussed in these studies that restrict access to health care for this population is lack of health insurance (Solorio et al, 2006). Low rates of health insurance amongst the homeless youth population are a known barrier to accessing health care (Solorio et al, 2006).

In Durban in South Africa, for these particular mothers, the equivalent to health insurance is an ID or a birth certificate, as discussed above under 'access'. It is the one thing that would enable these women to access health care without any help from another person, which is what health insurance would represents for homeless youth in North America.

The second supply barrier identified by the participants was low quality care in the form of poor treatment by health care personnel. Bad treatment of patients is here defined as a supply barrier because it creates difficulties in providing good health care to the young homeless mothers for the health care system. As McIntyre and Gilson (2002) argue, the effort made in reducing barriers to access by removing user fees is threatened by the some of the negative attitudes among health workers towards this policy, which possibly have resulted in poor treatment of some patients.

Thandiwe gave an example of how she was treated poorly when she sought health care. She explained that the main reason she did not like to go to the clinic was because she was scared of injections. However, when she was asked how she was treated if she went to a clinic, she explained that she used to get shouted at. She said that she did not like being shouted at, and that it was something that made it difficult for her to go to a clinic.

"*They shout at you at the clinic. When you tell them that you are sick, they say you must tell them what you have, and when they inject you they don't do it delicately.*"

Thandiwe

How young homeless mothers perceive health care workers and health care facilities that they use is valuable information when wanting to improve access to health care for this population (Wen et al., 2007). Experiences of bad treatment can influence their perception of health care services, and in this study there were several of the participants who told of encounters with health care personnel that made them not want to go to a health care clinic.

When talking about getting help at health care clinics during one focus group, Jabulile expressed that she was treated badly as a direct consequence of being homeless. She understood the lack of help as a result of her being a street kid, and that the personnel who treats them badly do not care about them because of this fact. They manner in which she expressed herself stress the low quality of care that these young homeless mothers sometimes receive;

"*..me, I want them to treat me the same, not that because I am black, because they don't treat us the same, they must treat us like every other people. Because when you go to the clinic when you are a street kid they don't help you the way they are supposed to. They only help you when they see that you are severely sick, but when you are just sick they don't really help you. When you are sick, they don't help you, but they should, because some of us are in that status when we need help. Sometimes they don't care about us*."

Jabulile

This participant also expresses that she sometimes is discriminated against due to her being a 'street kid'. That homeless youth or street kids make up a stigmatized population which often meet discrimination when they seek health care is documented in other studies as well (Haldenby et al, 2007).

Low quality as a supply barrier to health care for homeless youth has been discussed in research regarding access to health care for vulnerable groups (Ensor and Cooper, 2004, McIntyre and Gilson, 2002). Ensor and Cooper (2004) label poor treatment from health care staff as a supply barrier because it hinders the intended supply of health care. The staff might have bad attitudes because of poor management, low wages or having to work with undesired tasks. If the staff has bad attitudes, the patients receiving the treatment might suffer as a consequence (Ensor and Cooper, 2004). If health care workers have bad attitudes towards the patient, it might result in bad communication. When there is a lack of communication, the health care worker is not able to listen to the patient, and the patient might not comprehend the advice the health worker is giving. It has been shown that homeless youth tend to listen better to health care workers who treat them good, and are more likely to listen to their advice as a consequence (Ensign and Panke, 2002, Hudson et

al, 2008).

6.3.3.2 Demand barrier

Based on the information that came out of individual interviews and focus group we found only one prominent demand barrier amongst the young homeless mothers in this study. This was a lack of willingness to seek health care. The participants' accounts for not wanting to seek health care was based on their previous experiences with health care services. The fact that health workers treated patients poorly in this study is based on the accounts of the participants, and was not observed by the researcher herself. However, other studies from South Africa have shown that there is a tendency amongst health workers to have poor attitudes towards vulnerable populations seeking health care (McIntyre and Gilson, 2002, Schneider and Gilson, 1999). The issue of poor attitudes among health workers in South Africa will be discussed further under 'quality'.

This demand barrier is closely linked to the supply barrier discussed above where poor treatment creates difficulties with delivery of care. Previous bad experiences with health care where the mothers had been shouted at or yelled at and felt discriminated against worked as a barrier for them to seek further health care. It was something several of the participants mentioned during both interviews and focus groups, and it was also something that was confirmed by staff with Umthombo.

"*If you go to a clinic, how are you treated?*"
"*A, the nurse used to shout at me*"
"*Shout?*"
"*Yeah, they say I am too young for a baby, how can I have a baby, all those things.... They don't treat me very well. That's why I don't like to go to clinic, cause they will shout at me.*"

Nozipho

Discussions during the focus group also revealed that poor treatment affected the willingness of the participants to seeking health care. Although there were some participants who explained that they thought health care workers treated them nice, there was a general agreement that health workers used to shout at them, and that this was not alright. The shouting usually revolved around the fact that the participants where homeless or that they where young mothers, or a combination of these two issues.

When discussing the issue of how the participants used to get treated when they sought health care, we also asked them how they like health care workers to treat them. For some of the

participants this was not an issue as they thought they were treated just fine, however, others who had experienced poor treatment expressed a wish of being treated just like everybody else. Nozipho said that she wanted to be treated like others, that they should give her the medications that she came for and also ask her what she wanted. Nompilo, who was living with her baby, had also experienced not being listened to;

"*They treat me well, but when the baby was sick they did not treat me well. I told them that the baby was sick, they didn't give me anything, I explained that the baby was hot, they didn't give me anything...*"

Nompilo

Nompilo experienced not being listened to when she brought in her baby. She did not find it difficult to seek health care, however, the utilization of the care was more difficult as she did not receive what she went to get. When asked how she would like to be treated when she sought health care she explained that she would like it if they gave her something that would help her with the baby; 'things like medicine'.

Although poor treatment was the principal influence on lack of willingness to seek health care for the participants, the fact was that the majority of them did go to clinics when they needed health care shows that even though it was a barrier it was not sufficient for them to avoid using health care services. However, that better treatment would make it easier to seek health care at a clinic for the participants, and that this would have a positive effect on their health is important to consider. This has also been shown in other studies were they discuss the importance for the health care workers to acknowledge the homeless youths' need for emotional support (Hudson et al, 2008, Weinreb et al, 2006).

The issue of poor treatment being a demand barrier has been discussed in several studies (Ensign and Panke, 2002,Haldenby et al, 2007, McNamee et al, 2009). Haldenby et al discuss that fear of discrimination functions as a barrier to care. Homeless youth in their study refrained from going to health care services because they were afraid of being judged by the personnel (Haldenby et al, 2007). Fears like these are confirmed through other studies and reviews that have found negative dispositions among health workers towards homeless people (Haldenby et al, 2007, McIntyre and Gilson, 2002, Schneider and Gilson, 1999). This study from Durban confirms these findings.

6.3.3.3 Other barriers

Other studies that discuss barriers to health care for vulnerable populations talk about several barriers that were not brought up among the participants in this study. These barriers are usually connected to economy, education, cost and distance. Most of the barriers discussed in the literature are demand related. Gulliford et al (2002) talk about financial barriers as defined by Pechansky and Thomas in their article about what access means. This could be the cost of travel, if there is a health care facility or enough health care facilities in the area, or the cost of the time you spend going to the facility (Gulliford et al, 2002).

Since the participants in this study lived down town on the streets close to a major health care facility and were unemployed, time, work and distance was not an issue that came up during data collection. They could walk to the health care facility in 10 to 15 minutes and they did not pay to get there. Further, the time they spent getting to the health care facility did not cost them in terms of lost work-time. Primary health care in South Africa is also free, so financial barriers was not a major issue in this study from the perspective of the young homeless mothers (Burgard, 2004, Gulliford et al, 2002).

Another important demand issue is the economic situation of an individual (McNamee et al, 2009). In an overview on use of maternal health care this was the most important indicator for using the services; the higher the economic status, the higher the utilization of services (McNamee et al, 2009). In our study the participants belong to one of the lowest socioeconomic groups of society. However, economic status and its effect on utilization of health care did not come up in this study as being very important to the participants. As mentioned before, primary health care is free in South Africa, and thus economical cost of health care was not brought up by the participants. That they were of a lower class in terms of economic status had little effect on their usage of health care services in terms of economic means. A similar finding comes from a study in Pakistan where people of lower economic status were found to utilization of health care more frequently. Their low economic status was connected to unemployment, and thus they had more time to spend accessing and utilizing health care than those who were employed (Ensor and Cooper, 2004).

McNamee et al (2009) also look at educational level as an important demand issue for accessing health care. There is a tendency that higher utilization of health care is connected to higher levels of education. The participants in this study only spoke briefly about their education when discussing whether or not they knew of their rights to health care. Most of them had very few years of schooling, and many said they did not remember much if it. However, a few of the

participants said they learned about rights to health care at the clinic during various visits. It is difficult to say something about the effect of the educational level of these young mothers had on their utilization of health care as it was only briefly discussed during some of the interviews.

The issue of supply and demand barriers is a recurrent one in several studies on access to and utilization of health care (Ensor and Cooper, 2004, Goddard and Smith, 2001, McIntyre and Gilson, 2002, McNamee et al, 2009, O'Donnell, 2007, Oliver and Mossialos, 2004). One of the issues they discuss is whether the focus should be on supply barriers or demand barriers in order to improve the situation of access to and utilization of health care for vulnerable populations.

In the past there has been a tendency to focus on supply barriers when discussing improving health care access and utilization for vulnerable populations. However, several studies have shown that to improve access to and utilization of health care for vulnerable populations in low income or developing countries the focus has to be on both supply and demand barriers (Ensor and Cooper, 2004, McNamee et al, 2009). In this study we also found both supply and demand barriers to be important for improving access to health care for young homeless mothers. This is because two barriers identified by the participants in this study were influenced by one issue; the quality of care. Quality of health care was something very important to the homeless mothers in this study as it was a recurrent issue during discussions in interviews and focus groups. The quality of health care is in this study defined according to the perceptions of treatment the participants received by health workers, something that will be discussed further under 'Quality'. Since quality of care was what meant most to the participants when seeking health care, and it affects both supply and demand barriers in this study, focusing on both supply and demand barriers is equally important when discussing how to improve the situation of access to and utilization of health care for young homeless mothers.

Another reason for why the focus should be on both supply and demand barriers is that it can be difficult to differentiate between them in relation to health care. Supply and demand barriers are in many instances both connected and dependent on each other (O'Donnell, 2007). O'Donnell argues that demand and quality are highly connected and that health care with low quality often results in low demand. This is based on that even though health care is free, like in South Africa, the low quality has a greater effect on demand than if the fees for care are removed (O'Donnell, 2007). In this study we found that being treated poorly by health care personnel was both a supply barrier and significant influence towards a demand barrier. It was a supply barrier in that it created difficulties for the health care system to provide health care to its patients, and it was an influence

towards a demand barrier as it deterred the participants from wanting to seek further health care. That primary health care in South Africa is free, and it probably made it easier for the participants to seek health care, however, the low quality of care still influenced them and made the decision to seek health care difficult.

Some studies argue that one should focus more on demand barriers when dealing with vulnerable populations and health care. Ensor and Cooper (2004) discuss that for vulnerable populations in developed countries, and for populations in low-and middle-income countries, there is a tendency for demand issues like education and information, consumer cost, and community and household preferences to be the most important influences on access to and utilization of health care (Ensor and Cooper, 2004). This is because these issues often hinder the poorer segments of the population to take advantage of the health care system, even though it is well funded by the state. They argue that demand barriers should be the focus of interventions if we want to improve the situation for this population (Ensor and Cooper, 2004).

McNamee et al (2009) argue that the focus should be on both demand and supply barriers as it is difficult to know which ones are more important. They argue the importance of barriers vary by context and setting, and therefore one must know the local circumstances to determine which barrier it is that creates the most difficulty to access and utilize health care (McNamee et al, 2009). In our study we have learned that supply and demand barriers are more or less equally important as most of the barriers are influenced by how the health care staff treat the participants, which was something very important to the participants when they talked about seeking health care.

To diminish demand barriers to health care among the participants in this study one has to increase their willingness to seek health care. To accomplish this, they have to receive good treatment which according to the statements of the young homeless mothers is being 'treated nicely', 'with respect', and 'like a patient'. However, it is the health workers who are in charge of giving the participants treatment, whether it is good or bad, which further results in high or low quality care. Thus, to diminish demand barriers to health care for young homeless mothers, one also has to work on the supply barriers to health care.

6.3.4 Quality of care and the role of health care workers

A central theme in the findings from this study is how the participants were treated when they sought health care. As explained above we have interpreted what the participants said about how they were treated by the health care personnel and if they got what they expected as indications of good or bad health care. The quality of care received by the participants is thus based on how they were treated by health care personnel. This is in accordance with Campbell et al's (2000) definition of quality of care, which puts great emphasis on inter-personal interactions between health care workers and patients as part of what influences quality of care (Campbell et al, 2000). To assess quality of health care for young homeless mothers in Durban was one of the objectives of this study, and the findings on this issue will be presented here. The findings will be presented first, and then a discussion on them will follow.

When we asked the participants about experiences with treatment we did not set a specific time frame for the last visit they could refer to, and due to this the participants referred to both recent and past experiences. Some talked about getting yelled at, being treated rudely, and not getting the help they came for, and some talked about being treated nicely and with care, and getting what they wanted. Some effects of the poor treatment have been discussed above as barriers to health care. Further findings on the issue of quality of care will be discussed here.

From the interviews we found that the majority of the participants had good experiences, but about half of the participants who talked about being treated nicely had bad experiences with health care personnel as well. That some of the participants had both good and bad experiences came up when the issue of treatment was brought up in the focus groups after the interviews were concluded. Some of the participants who had told of good experiences during the interviews now told of being treated poorly by health care personnel. Possible explanations for why this happened have been discussed under 'methodological difficulties' above.

We assume that the setting for the individual interviews made it more difficult to discuss some issues than in the focus groups for some of the participants. We also base this belief on the fact that homeless youth often form strong relations to each other because they are in the same situation and because they share similar experiences (Haldenby et al, 2007). Haldenby et al (2007) found that homeless youth felt supported and cared for by other youth living on the street as they shared similar experiences, which they could talk about amongst each other without being judged (Haldenby et al, 2007).

Strong bonds between homeless youth could make it easier to discuss sensitive issues in

plenum rather than alone with two 'researchers', where the participants can feel inferior in terms of power relations. The young homeless mothers in this study all knew each other, some more than others, and we selected participants for the focus groups with emphasis on that the participants got along. Also, the power relations were more equally distributed in a focus group setting, where the participants were the majority and the 'researchers' the minority. Thus, we trust that what was said in the focus groups on the issue of treatment were true accounts. However, we also believe that what some participants said about good treatment during the interviews was equally true, and so we conclude that the participants in this study experienced both good and poor treatment by health care workers.

We will begin this section with the bad experiences related to treatments by health care workers, and then we will present what the participants said about good treatment. Next we will present how some participants acknowledged that all health care workers were different, some were good, some were bad. Then some perspectives will be shown on how the health care workers also can be a source of support and care for the young homeless mothers. Lastly, we will present the perspective of the staff with Umthombo on treatment of young homeless mothers by health care workers.

The participants who spoke of bad experiences at a health care facility often mentioned being yelled at and having to wait a long time to get help. Many also spoke of incidences where they had been treated rudely with a lack of understanding for why they were there.

"*In ..... they are discriminating. When you are sick, you can wait for a doctor. You'll wait for the doctor, maybe you went there at 8, at noon you are still waiting, some people who come after you will see the doctor. It happened to me.*"

Mbhali

"*When I get to the clinic, I take a number, we pray, when we are done, they'll say if you don't have a clinic card come this way. And when they shout at people who don't have a clinic card, they say 'why? You didn't get sick since you were born?' things like that. I don't like to be shouted at.*"

Thandiwe

As discussed above, this type of treatment acts as a barrier to health care for several of the participants in this study. Some of them expressed deep frustration over poor treatment, especially about having to wait long hours to see a health care professional.

When participants told of good experiences with seeking health care they spoke of being

treated well by the doctors and nurses and that they had given them what they came for. Some also expressed satisfaction because the personnel had treated them like other patients. Being treated like a normal person, and not like someone who lives on the streets meant a lot to the participants. Being treated with respect and spoken to nicely, and being taken seriously with regards to why they came for help are the factors that determine whether or not a visit to the clinic was regarded as good or bad.

"*they treat me well, they welcome me and they don't ask difficult questions. When I am pregnant they ask a question because I am underage; how am I going to take care of the baby, where I am staying, and I only explain about my situation if I want to. And if there is something they can help me with, they help me*."

Nobuntu

Something several of the participants agreed upon was that not all health care workers were bad. Some were bad, some were good, and you never knew how you were going to be treated.

"*some are right, some are wrong. Because maybe I go to the hospital at 6 o'clock in the evening, when they go for tea-time around 7, when they come back they sit and talk amongst themselves, that time you are so sick and very tired from sitting on the bench. Maybe they will call you after a long time, sometimes you don't even hear them calling your name because you fall asleep, then they ask you why you were just sitting... Sometimes you find those ones who are good, that's why I am saying they are not the same*."

Lindiwe

Some of the participants also talked about that even though they sometimes got treated harshly by the health workers they still considered them as nice. They expressed an understanding of the tough treatment as a form of caring and that they were only doing their job. Nomsa said that she used to be shouted at because she was homeless, which made her angry. However, after some thought she realized that they only wanted what was best for her, namely to go home, and she understood that they were telling her the truth. With this realization she stopped being angry.

"*They like me because they wanted me to go home. I got angry when they were still telling me, but when I was alone I understood they were telling the truth. I don't get angry anymore*."

Nomsa

How the health workers treat the homeless mothers plays a role outside of just medical access. Some of the mothers expressed that health workers treated them very good, and these same mothers also talked about health workers as more than just people that give them medical attention.

Some expressed that they received emotional care and support from health workers, and that they would go to the hospital not just for medical attention, but also just to talk.

"*...they always tell me if I have got any questions to ask, I am free, even if I got problem of the streets, I can come any time to them and sit down and talk to them. I mustn't be shy, and even if I got any questions I can go there and ask them, even if they are busy, I can only go there and wait until they go to lunch time, then I can be able to talk to them. Even if I am not sick I can go there and talk to them when I am, when I don't have no-one to talk to, when I am feeling like bad things or when I am not feeling right, I can go talk to them*."

Jabulile

Jabulile expresses that she feels welcome to go and talk to certain health workers when she has a need to. The health workers have been open for her to come and ask for advice any time she would like. This participant talked about how she went and talked to certain health care workers in both her interview and in the focus group she participated in. The manner in which she expressed herself when she was talking about the health workers indicated that she felt she was well liked by them and that they treated her like one of them. That homeless youth like to be treated like an equal, with respect and understanding is also found in other studies on access to health care for this population (Ensign and Panke, 2002, Hudson et al, 2008).

From the perspective of the staff members at Umthombo there were mixed opinions on whether or not young homeless mothers were receiving good quality health care. Some said they received the same health care as everyone else, and as themselves, so yes, the quality of the care was good. Others said that unless a member of Umthombo or a social worker was with a young homeless mother when she sought health care, the quality of care was questionable. Then the most likely scenario would be that the health workers would yell at the woman because she was too young to have a child, or refuse her care because she did not have ID, birth certificate or proof of residence.

Several of the staff at Umthombo also mentioned that stigma was an issue amongst health care workers when talking about HIV and AIDS and young homeless mothers. If someone is being judged because of a perceived or actual illness, or of their status as a homeless person, and receives care that is different from normal care, they expressed that stigma influenced the quality of the care.

"*you can imagine, you go to the hospital, they call your name, and lets say for example you are 16 years old and the person is looking at you and 'doll, oh, you know what she had an unprotected sex', and all those kind of stuff, you know. So yeah, stigma is one of the huge things that I think South Africans will have to deal with*."

Umthombo staff

Above we discussed the mobile health clinic that Umthombo runs. This health care option was very well liked amongst the participants in this study. This could be because it was a service that was provided to them specifically, and that the people operating the mobile clinic were used to and prepared to work with homeless youth so they did not suffer any discrimination.

The quality of the health care offered with the mobile health clinic is relatively good. For the injuries they deal with, as mentioned above mostly superficial wounds and other infections, the level of care is good. The mobile clinic had the equipment to deal with these kinds of injuries, and the patients seemed satisfied with the help received. The volunteers and staff at the mobile clinic were also very friendly with the patients, which adds to the perception that they offer good quality care. Some of the participants said that they preferred to talk to the staff at Umthombo when they felt sick.

"*Sometimes, sometimes, I just sit down, I don't tell anyone. But most of the time, when the, when other miss and the sirs from Umthombo, when they come, I just talk to them, I need to, we need to have a small meeting with them because there is something that is worrying me inside that I cannot keep.*"

Jabulile

Jabulile had a good relationship to several of the staff at Umthombo, and was often observed talking to them. During her interview she expressed that her first choice of who to talk to when she was feeling sick was the staff at Umthombo. This implies that the staff at Umthombo has a good relationship and connection to young people who live on the street, and that they should be utilized when creating better access to health care services for this population. The good connection is possibly created from years of work with homeless children and youth, but also from the fact that most of the staff at Umthombo have previously been homeless themselves.

Haldenby et al (2007) found that homeless youth had a great desire to have meaningful relationships, and that these were most usually formed with people that they could share the experience of being homeless with. There was a tendency for homeless youth to feel abandoned and betrayed by former family and friends, and when they met people on the street they formed relationships based on empathy and mutual respect (Haldenby et al, 2007).

Some of the young homeless mothers in this study expressed a sense of connection to the people working with Umthombo. As mentioned before, most of the people working with Umthombo are formerly homeless, and thus have a profound understanding of what it is like to be

homeless. That some of the young homeless mothers expressed that they liked to talk to staff at Umthombo when they were sick, or under other circumstances, is most likely because they know that they will meet an understanding for their situation. The staff at Umthombo met the young homeless mothers with empathy and respect, and this was something that was highly valued. The understanding for the situation of young homeless mothers by the people at Umthombo creates a sense belonging, which again establishes trust and support, for the participants, something they have lost with their former family and friends. This type of relationships should be valued when trying to create better access to health care for young homeless mothers, as the staff can provide valuable information on what young homeless mothers need and want from a health care service (Haldenby et al, 2007).

A study that have looked at treatment of homeless in a health care encounter is Wen et al's study 'Homeless People's Perceptions of Welcomeness and Unwelcomeness in Healthcare Encounters' (2002). They discuss the issue of experiences with health care being an important influence on how homeless perceive seeking health care. They did a qualitative study in Toronto, Canada, with 17 homeless participants from male and female shelters. They found that previous bad experiences with health care tended to correlate with low utilization of health care. The study looked at how homeless people felt during meetings with health care workers. They divided their experiences into two dichotomies; if the participants felt welcome or unwelcome.

In Wen et al's (2007) study they used a framework for analyzing the respondents answers by Martin Buber. He discusses how people relate to each other and classifies it into two categories. The first one is when a person relates to another person as a human being with respect. He calls this 'I-You'. The second category is when a person relates to another person like an object, with a lack of respect. He calls this 'I-It'. Wen et al discusses how the participants in their study often feel like they are being treated like an object when they seek health care, that there is an 'I-It' relationship between the health workers and themselves. Encounters that could be labeled as a 'I-It' relationship was often described as encounters which lacked empathy and where the health workers failed to listen to the patients. In our study the participants also talked about not being listened to, being shouted at and being discriminated against when they described their bad encounters with health workers.

However, if the participants felt they were being treated nicely, a 'welcoming' encounter, there was an 'I-You' relationship. These were often talked about in terms of being listened to, that their needs were acknowledged and that the health workers empathized with them. Some of the young homeless mothers had also experienced good treatment from health workers in similar forms like these.

Wen et al (2007) suggest that Buber's framework of discussing relations between people in terms of 'I-You' and 'I-It' can be useful when analyzing accounts of homeless people's experiences with health care workers. It is an unusual way of looking at studies like this, however, it offers a relatively simple idea of how health care workers can think of treatment when it comes to homeless people and other stigmatized populations (Wen et al, 2007).

Some of the participants in Wen et al's (2007) study drew a link between the way they were treated and discrimination. They expressed that they believed that because they were homeless or because of their low social status they were being treated poorly. Homelessness is a stigmatized lifestyle, and people who are homeless have been shown to get poorer treatment because of it (Hudson et al, 2008). In our study there were also some of the participants who believed that they got poor treatment because of their status as homeless.

"..me, I want them to treat me the same, not that because I am black, because they don't treat us the same, they must treat us like every other people. Because when you go to the clinic when you are a street kid they don't help you the way they are supposed to. They only help you when they see that you are severely sick, but when you are just sick they don't really help you."

Jabulile

Jabulile spoke of both good and bad treatment when she talked about seeking health care, and she was also aware of how some health worker treated her and other homeless youth poorly, and as she explains, as a result of them being homeless. One could say that when the participant was treated badly, like the quote describes, she felt like she was treated like an object, there was a 'I-It' relationship between the health care workers and her. However, when the participant was treated like an equal, with respect and understanding, she felt like she was being treated like a person, and the relationship could be described as 'I-You'.

We have described how one of the main issues discussed by the participants in this study was the bad treatment they had received by health care workers. The ones who had experienced bad treatment gave it as a reason for not wanting to seek health care because they did not like the way they were treated, which for many included being shouted at and being discriminated against. A possible explanation for this bad treatment from the health care workers could lie in the policy of free primary health care, first made available for pregnant women and children under 6 years of age in 1994. This policy of free maternal health care received many positive reactions, however, also quite a few negative reactions, amongst others, from primary health care workers according to Schneider and Gilson (1999). Some of the negative reactions were that services were being abused, that women were encouraged to become pregnant, that free medication would be resold, and that

non-citizens would take advantage of the system by traveling to South Africa (Schneider and Gilson, 1999). These negative reactions to the new policy was also probably fueled by the fact that primary health care workers were not consulted before it was initiated, even though it was they who had to deal with the potential increased influx of patients (Schneider and Gilson, 1999). The negative reactions to the implementation of free health care had a severe and unintended impact on how health care workers treat their patients, especially those who are now seeking health care because it free (McIntyre and Gilson, 2002, Schneider and Gilson, 1999).

McIntyre and Gilson (2002) argue that the effect of removing user fees for primary health care and improving the geographical accessibility to health care has to be followed by improving the quality of health care as well. One of the biggest problems when it comes to quality of health care in South Africa is poor treatment of patients by health care workers. That primary health care became free without consultation with the people who actually have to deal with the new policy did not create renewed inspiration amongst them, as it created an additional burden to a already pressed work situation (McIntyre and Gilson, 2002). They argue that this is something that is working against the effort put in to reduce barriers to utilization of health care by the South African government (McIntyre and Gilson, 2002).

The participants in this study often felt that they were treated badly by health care workers. That the policy of free health care could have something to do with this is quite possible. The South African government removed a barrier to health care by making primary health care free, however, part of the effect has made another barrier to health care stronger; the poor quality of health care. The intention behind making primary health care free was good, however, the implementation was poorly executed, as the people who had to work with the new policy were not consulted. Several studies on homeless youth give the advice that the population that the intervention in intended for should be involved in the planning (Ensign and Gittelsohn, 1998, Hudson et al, 2008, Barry et al, 2002). With regards to the implementation of free primary health care, the health care workers in South Africa should have been consulted.

Ensign and Panke (2002) argue that in order to improve the situation of health care for homeless female youth health care workers have to become more knowledgeable on the specific culture homeless female youth live with. They have to learn more about homeless female youth's lifestyle, beliefs and adaptive attitudes to be able to understand how culture affects their health seeking behavior (Ensign and Panke, 2002).

Ensign and Panke (2002) argue that health seeking behavior is influenced by culture, which is a combination of learned and shared beliefs and norms. Culture affects how one thinks and acts in a society, also when it comes to behavior regarding health. Ensign and Panke (2002) claim that

homeless female youth share a culture which is based on how they cope as homeless. They argue that the best way to provide health care to this population is to learn about this culture and to focus on the resourcefulness that young female homeless possess (Ensign and Panke, 2002).

Health care workers who work with young homeless females have to base their delivery of care on cultural competency. This is a set of compatible behaviors, attitudes and policies that are used to enable professionals to work effectively in cross-cultural settings. When this framework is used with homeless youth it incorporates their health issues, history, environment and current circumstances to provide health care (Ensign and Panke, 2002).

In their study they show that young homeless females have a shared culture based on their way of life as homeless and their coping skills to manage their lives as homeless. In our study we also found several shared issues among young homeless mothers that help them manage their lives in down town Durban. Their perspectives on health, their agency in relation to accessing and utilizing health care, their status as mothers, their fluctuating state of homelessness where they often go home, and their connection to Umthombo are all similarities among several of the participants. These are issues that influence how young homeless mothers seek health care, and are issues that health care workers should gain knowledge about in order to be able to provide them with appropriate and good health care.

Ensign and Panke (2002) argue that there are two central issues within cultural competency that should be the focus when working with young homeless females; self-knowledge and power-relations. Self-knowledge recognizes the differences between health care workers and homeless youth. They have different backgrounds, beliefs and attitudes, and this needs to be recognized. When health care workers realize and respect their differences, and incorporate these into the delivery of health care, the grounds are laid for better communication between the two, which fosters better delivery of health care. The participants in Ensign and Panke's study expressed that most of all they wanted the health care workers to listen to them, to their concerns and perceptions on what health related issues they were experiencing (Ensign and Panke, 2002).

The other central issue is power relations. In a health care setting, the health care workers are in a higher power position than the homeless youth as they are the ones who deliver the care and the youth are the ones depending on this care. This is important for the health care worker to recognize. Both in Ensign and Panke's study and in our study, the participants expressed that they liked health care workers who talk to them nicely, treat them like others, and do not judge them because they are homeless. When they were treated like other patients, with a recognition for where they were coming from, they were more likely to listen to the health care workers than when they were treated poorly.

7. Conclusion, possible recommendations and limitations of the study

7.1 Limitations of the study

This study has several limitations. Most of them are due to methodological issues, and here we will discuss these limitations.

The researcher and the participants spoke different languages. The need to use an interpreter during interviews and focus groups might have changed the meaning of certain concepts and expressions. This language barrier might have caused limitations to the study. However, the important themes and expressions where discussed with the research assistant, which aided the researcher's understanding.

The participants in this study were chosen based on a method of convenience. The sample of participants were all identified through the help of Umthombo, and were all in one way or another known by the Umthombo staff. Homeless mothers who were not in contact with Umthombo were not included. The results from this study might not apply to other settings or other homeless youth in Durban who are not connected to Umthombo due to the method of recruitment.

The research assistant in this study worked with the organization that allowed the researcher entrance to the field. This organization, Umthombo, provided help and assistance to homeless youth and children in Durban. The research assistant aided the researcher with recruiting participants and she was a vital part of the data collection. This might have made it difficult for the participants to decline participation in the study. The information the participants provided in this study might also have been biased because of the strong connection the research assistant had with Umthombo, an organization most of the participants respected.

However, the research assistant had personal experience with homelessness, which was a valuable experience to draw on when discussing how we should conduct the data collection, and for understanding the data we collected. Her experience was also valuable in terms on connecting with the participants based on empathy and understanding.

Another aspect that is important to note when doing research with homeless youth is context. Several researchers have noted that generalizations about homeless youth and health is

difficult as experiences vary according to context (Haldenby et al, 2007). Also, homeless youth are not a homogeneous population as their life and experiences are influenced by 'gender, race, ability, or other social locations and identities' (Haldenby et al, 2007). This study is about young homeless mothers and access to health care in Durban, South Africa, so their experiences are shaped by the fact that they are mothers with or without their children, that they are living in a state of fluctuating homelessness, and that they are living under conditions that might be unique to Durban. These conditions might not exist in the same way in other urban centers, and can therefore create difficulties when comparing this study to other studies performed on homeless youth.

In this study we fully trusted the participants accounts of their encounters with the health care service. It has been shown that the accuracy of homeless peoples' accounts of health care interactions can be skew as there is a high prevalence of mental illness and substance abuse which could influence possible conceptions of a situation (Wen et al, 2007, Hudson et al, 2008). That we were unable to talk to any health workers who could verify the experiences of the homeless mothers, even though the staff at Umthombo did do this to a certain degree, could be a possible weakness of this study.

7.2 Concluding discussion and possible recommendations

In this study we have seen how a group of young homeless mothers perceive health and what their experiences with access to and utilization of health care are. It was thought that their experiences with the health care system would show that they had very low access to health care, however, these young homeless mothers have shown us how they cope with their lack of resources to overcome difficulties affecting their health seeking behavior.

The participants in this study perceive health as an individual responsibility. They associate healthy food and being clean with being a healthy person, and illness as something you have to protect yourself from. Other studies have also found similar perspectives, and argued that how one views health depends on the social surroundings of the individual (Flick and Röhnsch, 2007). An individual's view on health affect how she perceives what influences her health, and what she can do to stay healthy. Homeless youth often live with few resources, and this situation influences what they can do to protect their health. Trying to get hold of healthy food and staying clean are things they are able to do, and are issues that they talked about related to health. This indicates that they are focusing on the factors that they can control in relation to protecting their health.

The participants in this study showed relative awareness of health and illness, possibly a consequence of how the homeless lifestyle poses high risks to their health. The participants who were HIV positive expressed the importance of going to the clinic and receiving health care to be able to take care of themselves. Another issue regarding the social surroundings of our participants is that they are all mothers. This influenced the perspective on health for some of the participants in terms of taking better care of themselves after becoming mothers.

This study has also shown that young homeless mothers do have access to health care, however, the access is not optimal, and there is room for improvement. The participants in this study gained access through different channels, either with an ID or a similar document, by being accompanied by an Umthombo member or a social workers, or by possessing a certain form of agency. However, if they were able to access health care, they were not always able to utilize the services that they sought. This was a result of long waiting hours and poor treatment by health care workers. The participants expressed that they did receive help, however it was often accompanied by judgment, rude comments and shouting. This treatment was, according to the participants, because they were young homeless mothers. Similar findings have been found in several studies on homeless youth (Ensign and Gittelsohn, 1998, Ensign and Panke, 2002, Haldenby et al, 2007, Hudson et al, 2008)

Through interviews, focus groups and observation we were able to explore what caused difficulties for the participants in this study to access and utilize health care. We found three barriers, two supply barriers and one demand barrier. Not having an ID or similar documentation and low quality of care due to poor treatment were found to be supply barriers to health care as they hindered the delivery of care. Lack of willingness to seek health care was found to be a demand barrier. The biggest influence on lack of willingness was poor treatment by health care staff. We thus found that what is most important to focus on when trying to create a better health care situation for young homeless mothers in Durban is how health care workers treat their patients. Quality of care is the main influence on how young homeless mothers judge the quality of health care, and quality of health care is one of the most important issues when it comes to improving health care services, especially for vulnerable populations (McIntyre and Gilson, 2002, McNamee et al, 2009).

Several studies have shown the importance of being met with respect, support and understanding for homeless youth when they seek health care (Ensign and Panke, 2002, Hudson et al, 2008). In our study perceptions and experiences of treatment during health care visits make up the most important factor for how inclined the participants felt in terms of seeking health care. If

they were treated with respect they would be more inclined to keep seeking health care and listen to the advice of the health care workers, which could have a positive effect on their health (Hudson et al, 2008). The ultimate goal for many societies is to get homeless youth either back with their families if this is the best for the youth, or to be able to function like other individuals in the society. Good health is an important factor to be able to function is society, so creating a better situation for homeless youth to take care of their health is a priority. Health care workers play a crucial role in helping homeless youth take care of their health. Therefore it is important that health care workers acknowledge their responsibility when delivering health care to young homeless mothers (Hudson et al, 2008).

Homeless youth should be included in planning and interventions when it comes to ideas on how to improve the situation of health care for this population (Ensign and Gittelsohn, 1998). Their experiences and perceptions on health and access to health are valuable insights into what works for them when seeking health care. And after all, when an intervention is created to improve a situation for a specific population group, it would be a mistake not to take the advise from the people who will actually use the services. With the barriers described above and the other reasons why young homeless mothers might be reluctant to seeking health care, it is also important to look at what might facilitate or encourage them using health care services. The most important is maybe receiving good treatment.

Ensign and Panke (2002) suggests that in order for health care workers to be able to provide appropriate health care to homeless youth they have to base this care on cultural competency. This entails gaining knowledge of the culture in which homeless youth live. Homeless youth have their own culture that affects how they view health and how they act regarding health needs. Health care workers need to have an understanding of this culture and how it affect the perception of health for homeless youth. This understanding has to be combined with an awareness of the differences that exist between health care workers and homeless youth, in addition to recognizing the uneven power-relations that emerge in a health care setting between the provider and the receiver. If this is accomplished the circumstances for delivering health care to homeless youth would be improved.

Studies have found that homeless youth would prefer to seek health care from clinics that are targeted at homeless youth specifically (Ensign and Panke, 2002). The staff at Umthombo, who have been working with homelessness youth for years also thought that health care services targeted directly at young homeless women and mothers would make it easier for them to seek health care.

This is opinions and advice that should be considered when trying to create better health care services for young homeless youth in Durban.

Compared to other studies of homeless youth and access to health care, the participants in this study were more inclined to seek help at health care clinics than other homeless youth, in spite of poor treatment. The participants in our study mentioned less barriers to health care than what has been found with homeless youth in other studies. Amongst others, transportation and fees were not mentioned as barriers as the participants could walk to the nearest health care service and because primary health care in South Africa is free. That young homeless mothers have less barriers to health care than other homeless youth could imply that they choose to use health care services with more ease than other homeless youth. Due to this young homeless mothers view health care as a first option and not as a last option when they are ill, in contrast to homeless youth in Seattle (Ensign and Panke, 2002).

Another influence on the choice to seek health care is the level of awareness regarding illness amongst our participants. Some of the participant expressed how they sought health care regularly as a consequence of their illness, and the participants who were living with their children also expressed how the first option when their children were sick was to seek help at the nearest health care clinic.

These findings show that to have access to health care is important for the participants in this study. That they will seek health care in spite of the barriers they face is something we need to recognize and work with. One way of using these findings is to focus on what makes young homeless mothers in Durban seek health care, and use this to create a better provision of health care.

As mentioned before some of the research on homeless youth has in the resent past shifted from only focusing on their vulnerability and risk-behavior to focusing more on their coping-techniques and resilience (Rew and Horner, 2003, Zerger et al, 2008). These studies emphasize that we need to listen to the experiences of the youth and to what they want from health care services. In our study we have tried to to this by asking young homeless mothers about their experiences with using health care and how they would like to be treated when they seek health care. One of the issues that came out of this was the difficulties of accessing health care because they lacked an ID. An ID is also associated with more than just a way to access health care. It was viewed by many as a way out of homelessness as some of the mothers expressed that when they got their ID they could get a place to stay and a job. In this way getting an ID was associated with gaining a sense of independence as having an ID opened options to the mothers, including accessing health care

services on their own.

Based on the importance of having an ID in South Africa in terms of accessing social services, there should be a focus on providing homeless youths with IDs. It has been shown in other research that providing homeless youth with health insurance is probably one of the most beneficial strategies in terms of creating better access to health care (Ensign and Panke, 2001, Zerger et al, 2008). This is because it is listed as one of the biggest barriers to health care for this population, and eliminating it as a barrier leaves one less obstacle for homeless youth to take care of their health. The same goes for providing young homeless mothers in Durban with an ID, it makes it easier for them to take care of their own health, with is what they want.

With this study we have found that we should focus on young homeless mothers' strengths rather than their vulnerabilities (Ensign and Gittelsohn, 1998). Barry et al (2002) also stress the importance of respecting the strengths and skills of homeless youth to create effective health care services (Barry et al, 2002). The participants were able to access health care in spite of the barriers they had to overcome. Although full utilization of the services became difficult due to harsh treatment from health care staff, they still chose to seek help as several of them were dependent on professional health care to take care of themselves and their children. These young homeless mothers were able to get the help they needed although they fall outside of the system as a group, and this is a strength we should focus on when trying to create better access to health care for this population.

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9. Appendix

9.1 Interview guide young homeless mothers

1. Can you tell me about what you do every day/ what a normal day looks like for you?

2. How many children do you have?
Probe;
- How old are they?
- How are they?
- Have they been sick lately?
- What did you when they were sick?
- What do you do to try to keep them healthy?
- What is most difficult in trying to keep your children healthy?

3. How is your own health?
Probe;
- Have you had any illness or pain lately?
- If yes, what did you do?
- How do you stay healthy?
- What is most difficult when you are trying to take care of your own health?

4. Where do you go if you are feeling sick?
Probe;
- Who do you prefer to talk to when you are sick?

5. Would you go to a health care clinic when you are sick?
Probe;
- In what way are you treated when you seek care at a clinic?
- Do you like the way health personnel treat you when you are at a clinic?
- If not, how would you like them to treat you?

6. Is it difficult for you to go to a health care clinic?
Probe;
- What makes you don't want to go to a clinic?
- Please give me some examples of what you want help with when you go to a clinic.
- Please give me an example of a typical meeting at a health care clinic for you.

7. What would make it easier for you to go to a health care clinic when you are feeling sick?

8. How or where do you learn about your rights in terms of health care?

9. Have you gone to school? If yes, for how long, and what did you learn about health, health care in South Africa, and rights to health care?

9.2 Interview guide Umthombo staff

1 What does your typical day at work look like?
Probe;
- What is your position at work?
- What are your responsibilities?
- How long have you worked with this organization?

2 Who are the people you work with who live on the street?
Probe;
- Do you work with young homeless mothers?
- Do you work with people who have HIV and AIDS?

3. Please give me some examples of what type of services you provide for young people living on the street.

4. How is the health situation of the people you work with?
Probe;
- Are the young people open about their HIV and AIDS status?
- What are the most common health issues of the people you work with?

5. Do the young people you work with have access to health care?
Probe;
- Are there special health clinics for young homeless people in Durban?
- Are some health clinics used more than others?
- Is it difficult for young homeless people to seek help at a health care clinic?
- What are typical problems/ barriers when young homeless people want to seek care at a clinic?
- What types of health problems usually make them seek care at a clinic?

6. In your opinion, what type of health care services do you think young homeless mothers living with HIV and AIDS in Durban, South Africa need?
Probe;
- Do you think that these services are available?
- Do you think they are of good quality?
- What needs to be done to provide good needed services to young homeless mothers living with HIV and AIDS in Durban, South Africa?

9.3 Focus group guide young homeless mothers

1 What does it mean to be healthy to you?
2 Who do you usually talk to when you are having problems with your health/ when you are feeling sick?
3 Is health more important to you after having children?
4 What would you do if your child was sick?
5 Are there any health care clinics available for you?
6 Do you get help at health care clinics?
7 What is most important to you when you seek health care?
8 Is having an ID important to get access to health care services?
9 What do you think of the staff at health care clinics?

9.4 Focus group guide Umthombo staff

1. What is the state of access to health services for young homeless mothers living with HIV and AIDS today? Is it good, bad, ok, changed? Why?
2. What are typical health issues for young homeless mothers living with HIV and AIDS? What are their most important needs from the health services?
3. Is there a difference in your opinion between women with children/ mothers and other women when it comes to health concerns?
4. What, in your opinion are the biggest barriers to health care for these women?
5. What, in your opinion, can be done to improve the health care services for these women?
6. Where and how, in your opinion, do the women learn about their rights in terms of health care?

9.5 Consent form

I have been asked to take part in a research project which is about the situation of young homeless mothers living with HIV and AIDS, and their access to health care. I have been given information on what the project is about, and why I have been asked to be a participant.

I agree to take part in this research project. I am allowing a witness to sign to confirm this on behalf of me.

Witness; Researcher;

Signature _____ Signature _____

Date _____